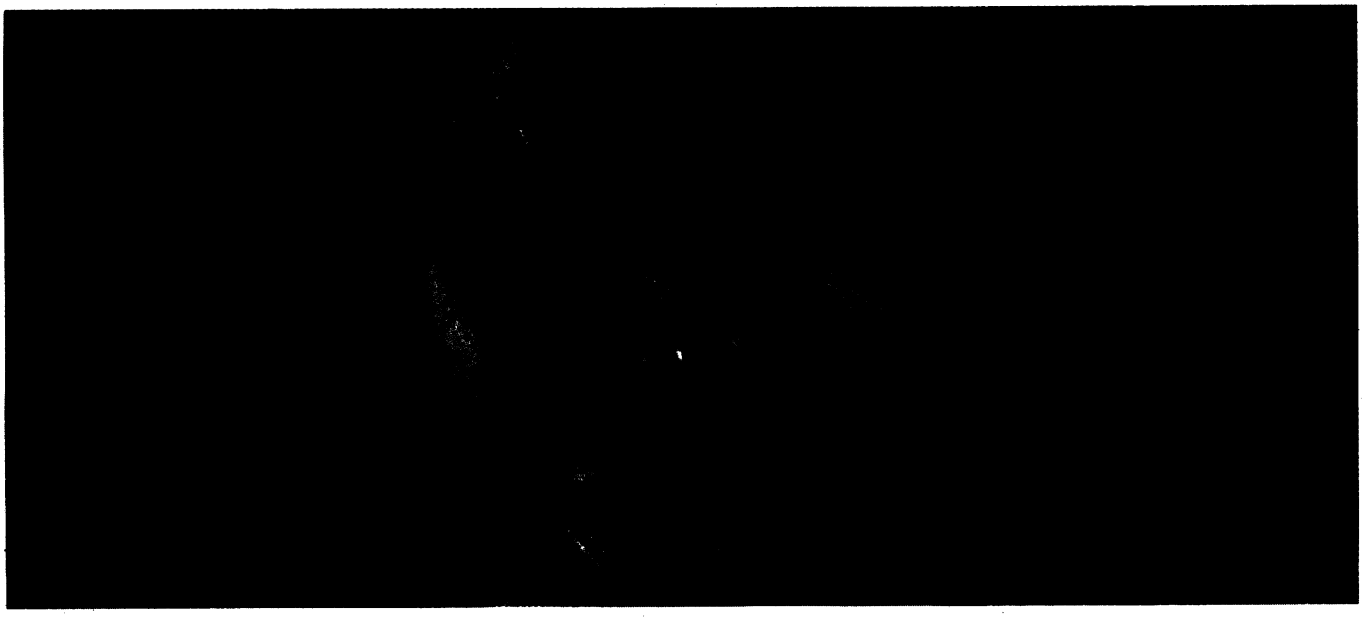
For pain of longer duration



Depronal·SA

SUSTAINED ACTION DEXTROPROPOXYPHENE HCl

Contains an analgesic you know and prescribe often.

—now in a unique sustained release mechanism

Pain-free days and restful nights for patients with arthritic disorders, post-operatively, post-partum, in dysmenorrhea, sciatica, traumatic injuries or strains and sprains.

Membrane controls ingredient release

Each pellet in a Depronal•SA capsule has a unique dialyzing membrane which controls the diffusion of active ingredient *regardless of gastric pH or enzyme activity.* Smooth and continuous drug release can be demonstrated over an 8-hour period.

Dosage: One capsule every 8 to 12 hours as required. Maximum of 3 capsules per day. Not recommended for children. NOTE: When anti-inflammatory and anti-pyretic effects are desired, salicylates may be administered concomitantly with Depronal·SA.

Composition: Each capsule contains 150 mg. dextropropoxyphene hydrochloride (propoxyphene HCl) formulated to be released over a period of 8 hours.

Side Effects: No serious side effects have been reported at therapeutic doses. Side effects which are seen infrequently include drowsiness, dizziness, nausea, vomiting, constipation, euphoria, excitement and insomnia. Itching and skin rashes have been observed occasionally.

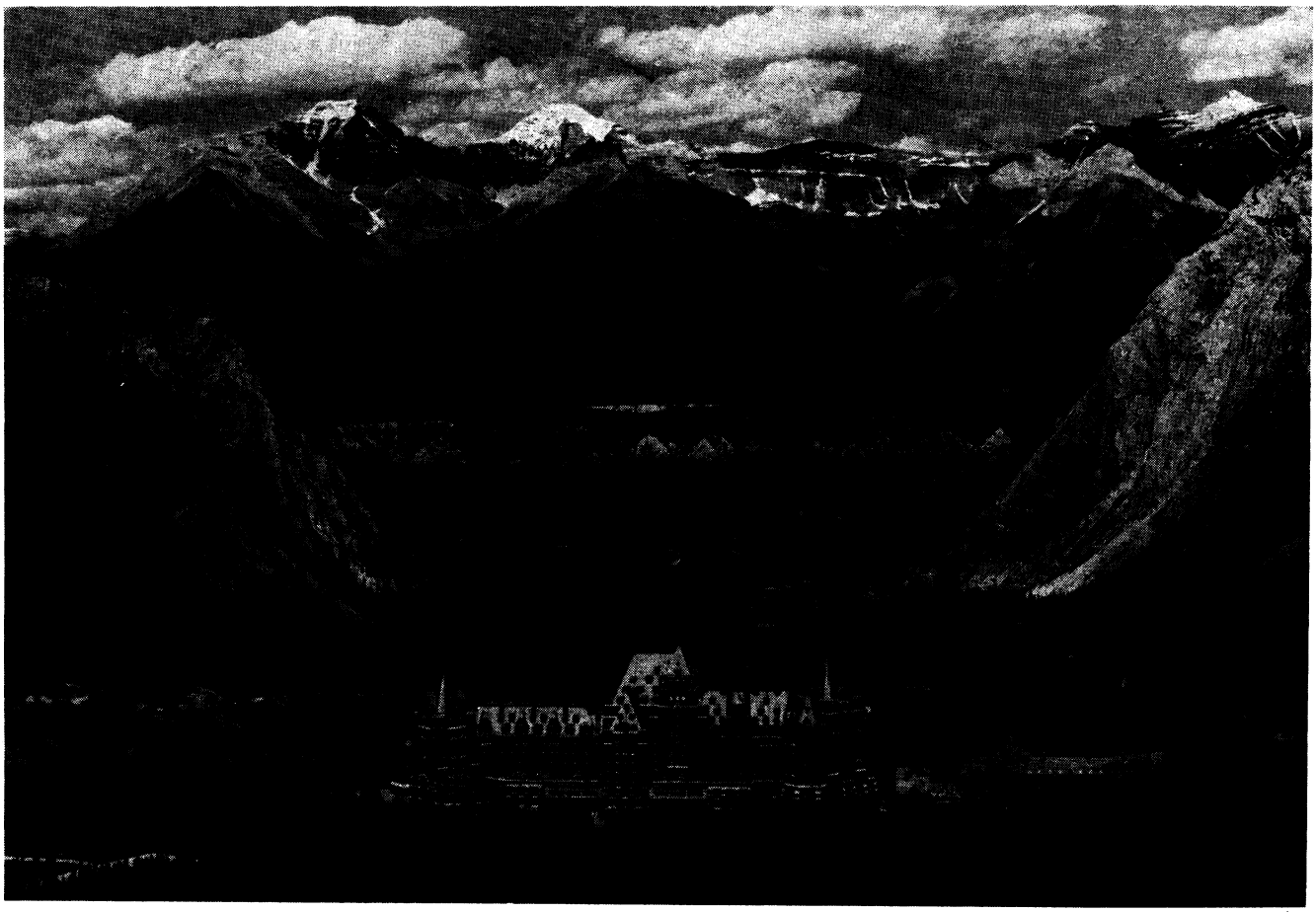
Contraindications: Contraindicated in those individuals sensitive to dextropropoxyphene. Not recommended for use with orphenadrine-containing compounds.

Supplied: Bottles of 50 and 250 capsules. Product monograph available on request.

Depronal·SA

SUSTAINED ACTION DEXTROPROPOXYPHENE HCl

WARNER-CHILCOTT LABORATORIES CO. LIMITED
Toronto, Canada



Education and the Family Physician

The Theme For

The 15th Annual Scientific Assembly

The College of Family Physicians of Canada

At The

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Banff, Alberta

September 13 to 16, 1971

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Cold Stress

Severely stressful conditions can greatly increase the body's requirements for ascorbic acid, and supplementary intake has been recommended – especially during exposure to cold stress.[1]

Requirements for B series vitamins may also be increased substantially, since these requirements are related to calorie turnover. A man performing even moderately heavy labor in a cold climate may expend 4,000 to 5,000 or more calories a day.[2] Suboptimal intake of thiamine, however, is probably fairly common in average diets.[3] Within recent years physicians have become increasingly aware of the possibility that mild thiamine deficiency may be fairly prevalent.[4] When cold stress precipitates a deficiency of water-soluble vitamins, consider the potential benefits of Surbex*-500.

*

Therapeutic B Complex with 500 mg. of C

References:
1. Conn, H. F., ed., Current Therapy 1969, W. B. Saunders Co., Philadelphia, 1969, pg. 405.
2. Pollack, H., and S. L. Halpern, Therapeutic Nutrition, NAS-NRC Publication 234, 1952, pg. 7.
3. Drill, V. A., ed., Pharmacology in Medicine, 2nd ed., McGraw-Hill Book Co., N.Y., 1958, pg. 886.
4. Goodman, L. S., and A. Gilman, The Pharmacological Basis of Therapeutics, 3rd ed., The Macmillan Co., N.Y., 1965, pg. 1655.

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CAUTION: Oral penicillin, rarely, may cause acute anaphylaxis.

Full information on request.

1. G. H. McCracken Jr., H. F. Eichenwald and J. D. Nelson: Antimicrobial therapy. J. Pediat. **75:** 5:742-757 (Nov.) 1969.

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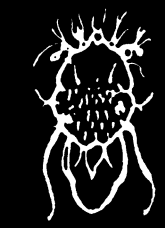

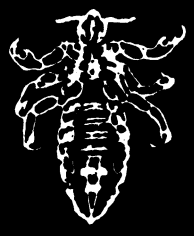

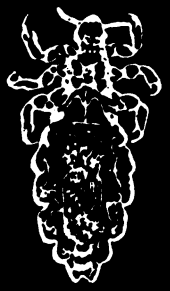

LICE & SCABIES ON CONTACT

Pesky ectoparasitic infestation is no respecter of persons. You're likely to come across one or the other of the unpleasant little fellows more frequently, whether your practice is private or institutional.

When it comes to treatment, just pick up any textbook of dermatology, parasitology or pharmacology. Chances are good you'll find the therapy specified for such infestations is Kwellada. (Kwell in the U.S.)

Kwellada is the formulation which is recognized as effective in cases where other preparations have failed. With the active pediculocide, gamma isomer of hexachlorocyclohexane, this remedy efficiently eradicates the parasitical cause, usually with one application. Applied directly it does not irritate the skin or cause other unpleasant side effects.

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KWELLADA SHAMPOO CREAM LOTION

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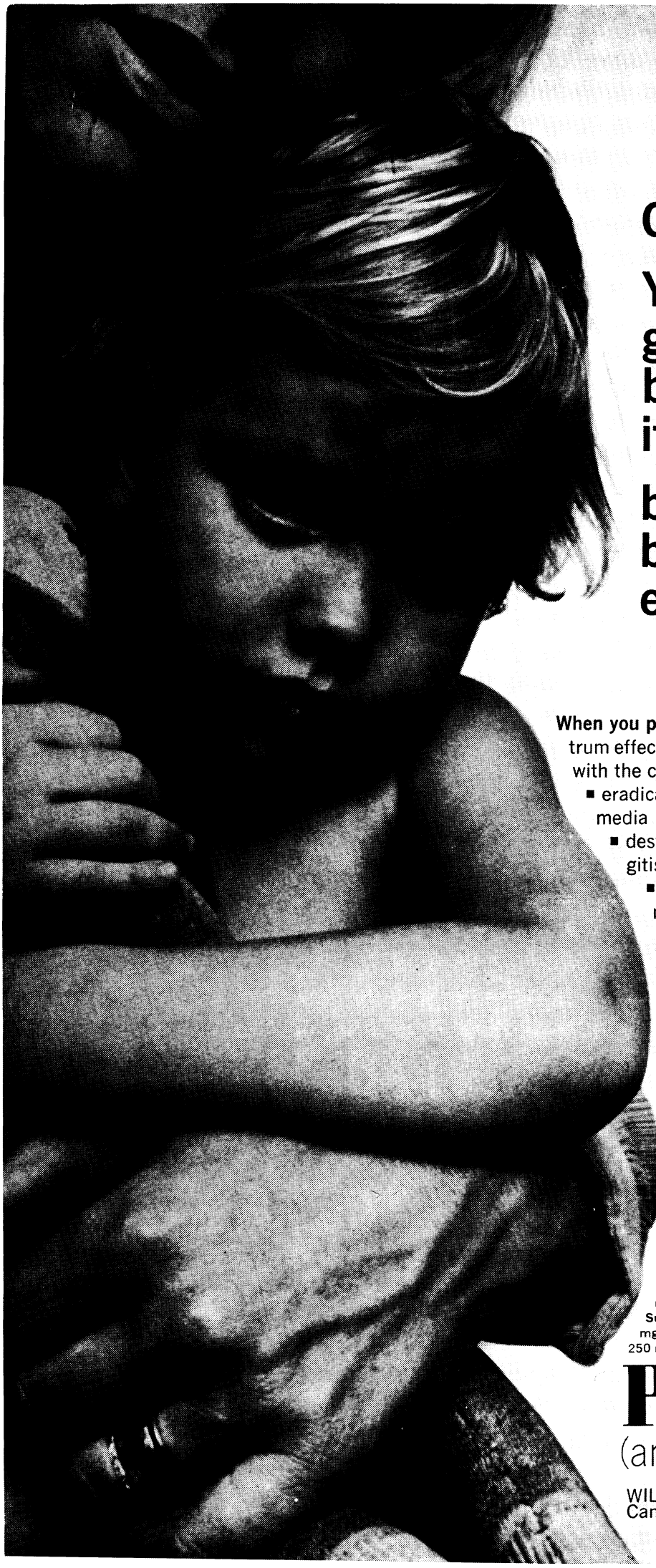

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but you want broad-spectrum effectiveness, too.

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- kills pneumococci—major sinusitis, otitis media and lower respiratory pathogens
- pleasant tasting suspension accepted by the fussiest patient
- new 100 ml. size gives full 5 day course of therapy at lower per day cost

PRESCRIBING INFORMATION—Product Monograph available on request.

Indications: Infections due to susceptible strains of Gram-negative bacteria including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, and *P. mirabilis* and Gram-positive bacteria such as streptococci, pneumococci and nonpenicillinase-producing staphylococci.

Contraindications: A history of allergic reactions to penicillins or cephalosporins.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions.

Usual Dosage: Adults—250-500 mg. q. 6 h. (according to infection site and offending organisms). Children—25-50 mg./Kg./day in 3 to 4 divided doses.

Supplied: *Capsules*—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 24. *For Oral Suspension*—125 mg./5 ml. and 250 mg./5 ml. in bottles of 60 ml. and 100 ml.

*TRADEMARK —AUTHORIZED USER

Polycillin*

(ampicillin trihydrate)

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Lasix® relieves hypertension

safely

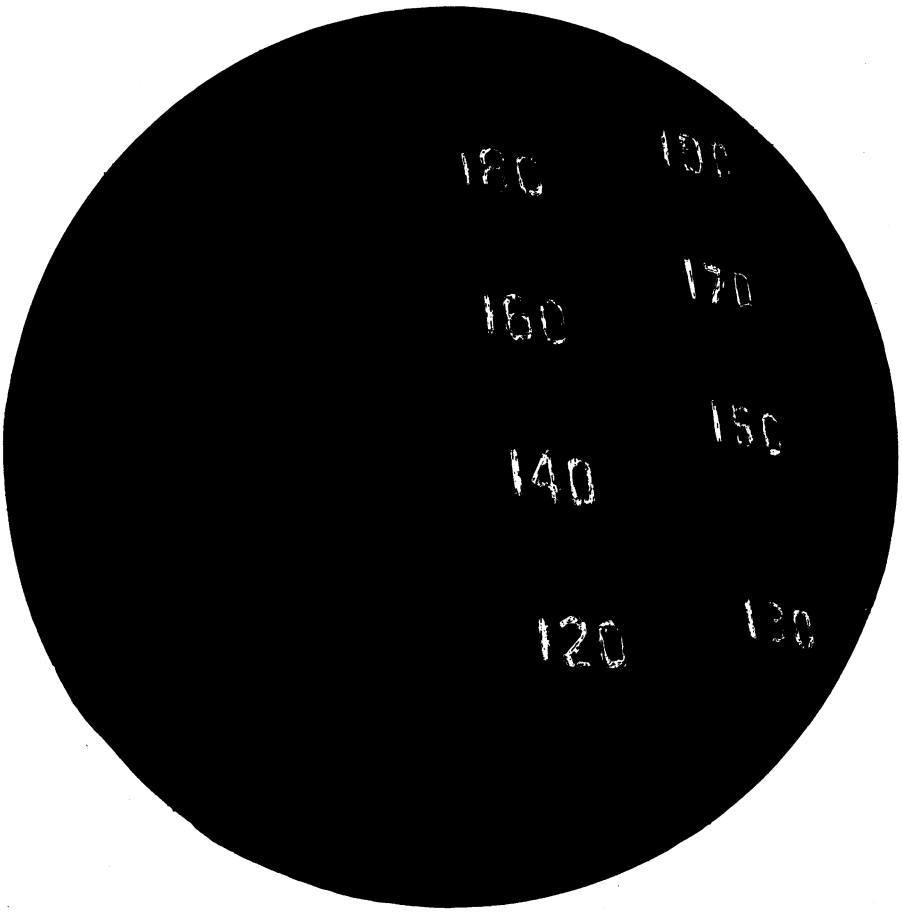
In the treatment of mild to moderate hypertension, safety is of prime consideration. Most hypertensive patients have some degree of impaired renal function.[1] The thiazides further aggravate renal impairment by reducing renal blood flow and glomerular filtration rate.[2] In contrast to the thiazides, Lasix lowers renal vascular resistance, thus improving rather than impairing renal function.[3] And Lasix assures a significantly better electrolyte balance and consistently less potassium loss than the thiazides.[4] Because of these specific advantages, of particular importance in long-term therapy, Lasix is the diuretic of choice in hypertension.

effectively

In the treatment of mild to moderate hypertension, clinical evidence has established that Lasix is clearly as effective as the thiazides. But unlike the thiazides, Lasix is effective even in patients with impaired renal function.[5] In severe hypertension, Lasix is effective when used in combination with other antihypertensive agents. The continuing efficacy and safety of Lasix in lowering blood pressure make it the diuretic of choice for initial and maintenance therapy in hypertension.

predictably

In the treatment of mild to moderate hypertension, Lasix demonstrates a predictable, sustained antihypertensive action. The blood pressure-lowering effect of Lasix lasts up to 24 hours,[6] thus providing smooth, continuous control of hypertension, even in prolonged administration. And predictable response also provides an easy-to-manage, easy-to-follow regimen. Lasix assures reliable, continuing efficacy in the long-term management of hypertension.



(1) Moyer, J. H., Heider, C., Pevey, K. and Ford, R. V.: Am. J. Med., *24*:164, 1958. (2) Kirkendall, W. M. and Wilson, C.B.: Med. Clin. of N. A., *52*: 1157, 1968. (3) Hook, J. B., Blatt, A. H., Brody, M. J. and Williamson, H. E.: Clin. Res., *13*: 424, 1965. (4) Mahabir, M. and Laufer, S. T.: Arch. Intern. Med., *124*: 1, 1969. (5) Joynt, M.S.K. and Morrin, P.A.F.: C.M.A.J., *99*: 1256, 1968. (6) Atkins, L.L.: Geriatrics, *21*: 143, 1966.

Lasix, the antihypertensive to begin with . . . and stay with

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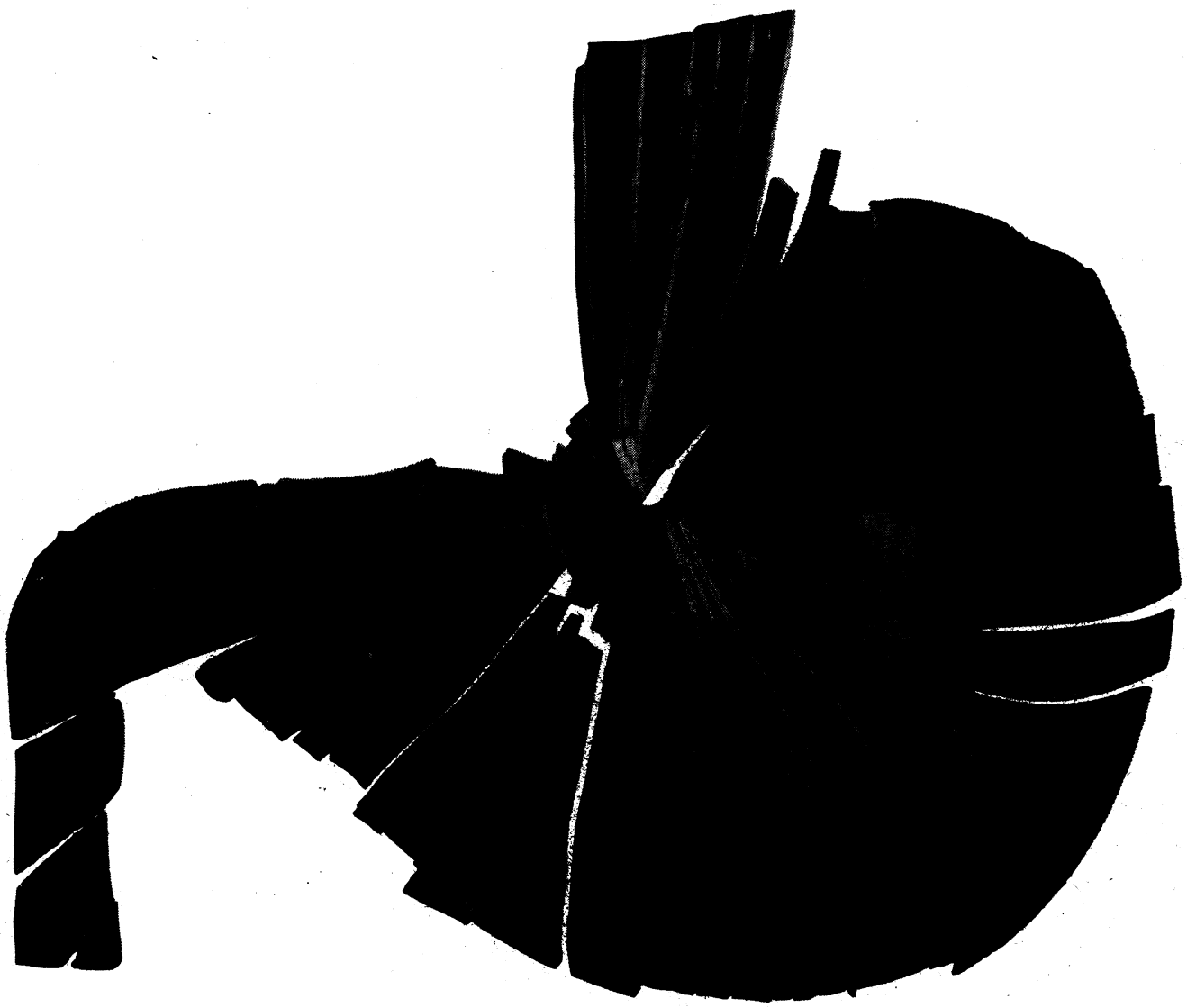

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First the relief of pain and spasm, then the selective inhibition of anxiety. Such is the action of Librax® on the somatic and the emotional symptoms of ulcer.

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takes the mind off the stomach and the stomach off the mind

Librax Roche Rx Summary: Composition: Each 'Librax' capsule contains chlordiazepoxide HCl 5 mg and clidinium Br 2.5 mg. *Indications:* Control of hypersecretion, hypermotility and emotional factors associated with gastrointestinal disorders such as peptic ulcer, gastritis, nervous dyspepsia, cardio-spasm and pylorospasm, biliary dyskinesia, irritable or spastic colon. *Precautions:* Abstinence from alcohol during treatment. Until dosage is established, caution whenever mental alertness or physical co-ordination is required. Periodic blood counts and liver function tests advisable in long-term use. *Contraindications:* Glaucoma. Caution in prostatic hypertrophy. *Dosage:* Average dose in adults: 1 or 2 capsules 3 or 4 times daily *before meals* and at bedtime. *Supply:* Capsules: 100,500,1000
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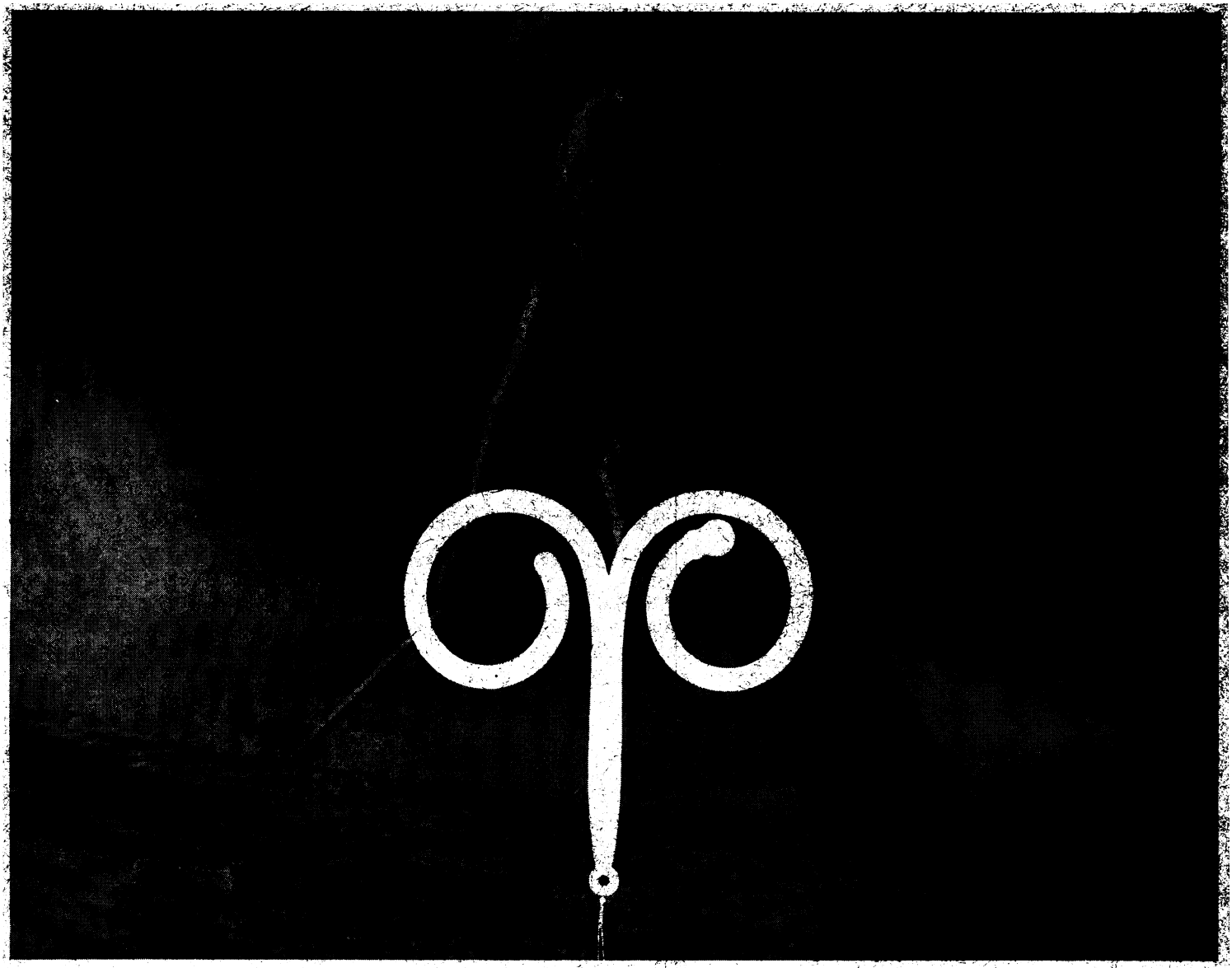
☐ Please mail my tickets & invoice me at the above address.



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1. Vaughn, B.J., and Dominguez, H.: Experience With Double-Coil Intrauterine Contraceptive Device. Postgrad. Med., *47*:179-183 Feb., 1970. 2. Hayes, O.J.: Clinical Evaluation of the Double-Loop in 200 Private Patients. Southern Gynecological and Obstetrical Society Meeting, reported in OB. GYN. NEWS, *1*:2, Jan., 1970.

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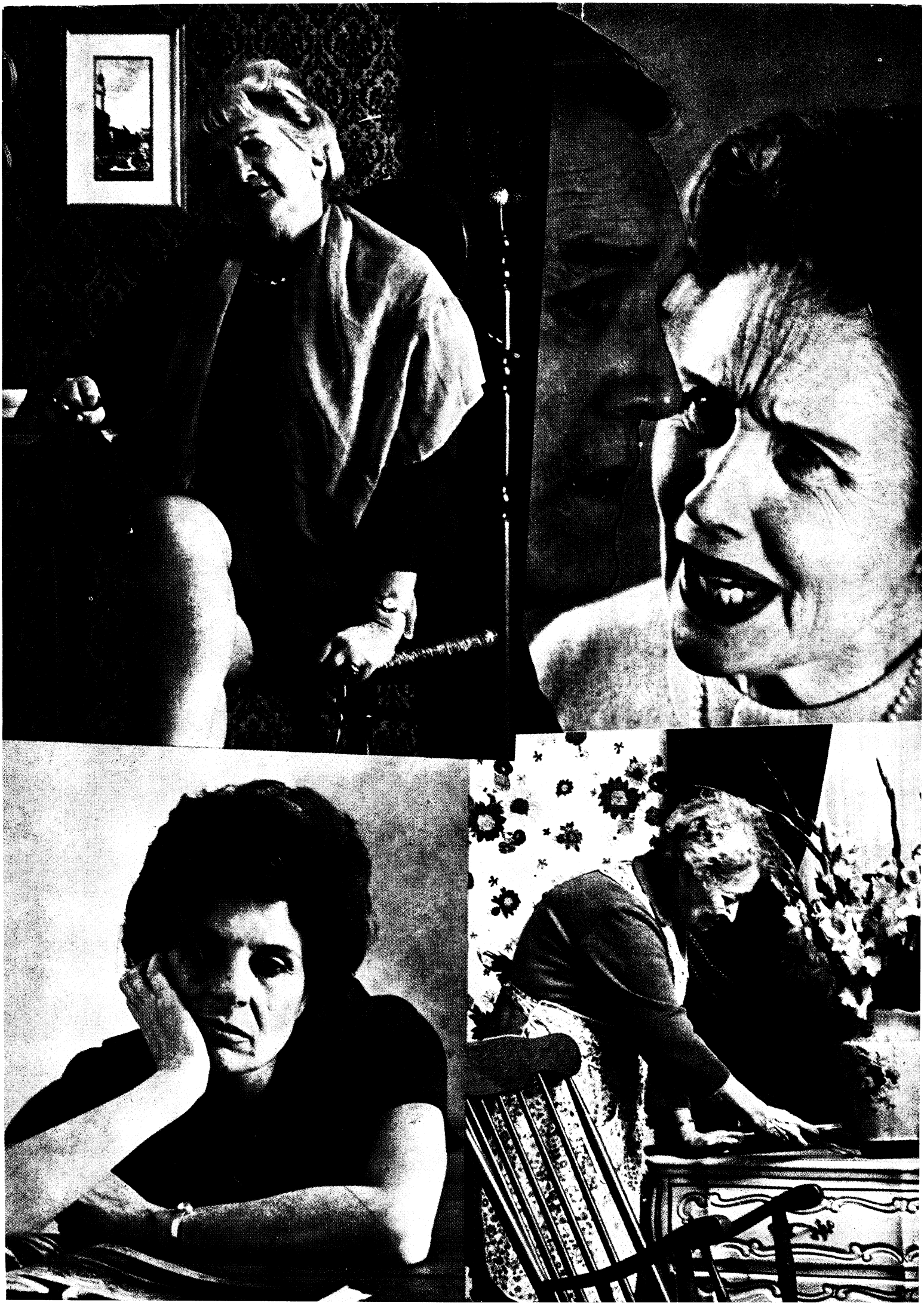

These women may be estrogen deficient.

They needn't be.

Endogenous estrogen deficiency can be a fundamental cause of emotional and physical degeneration in the postmenopausal woman: menstrual irregularities, hot flushes, irritability, depression, nervousness, headaches, low back pain, osteoporosis, atherosclerosis, atrophic skin and muscle changes, senile vaginitis, pruritus and kraurosis vulvae.

But it doesn't have to happen. Many of these aging processes may be minimized or prevented. PREMARIN*—the natural and complete estrogenic complex—acts as a metabolic regulator and exerts a protective effect on many systems, organs and tissues of the female body.

Moreover, PREMARIN has the intrinsic ability to impart a sense of well-being—of vital importance in this period of psychologic adjustment and emotional imbalance.

"If we consider the number of aging changes that take place in the body after estrogen deficiency begins, it would seem logical to treat all women . . . estrogens are as essential to good health as a well balanced diet."–†

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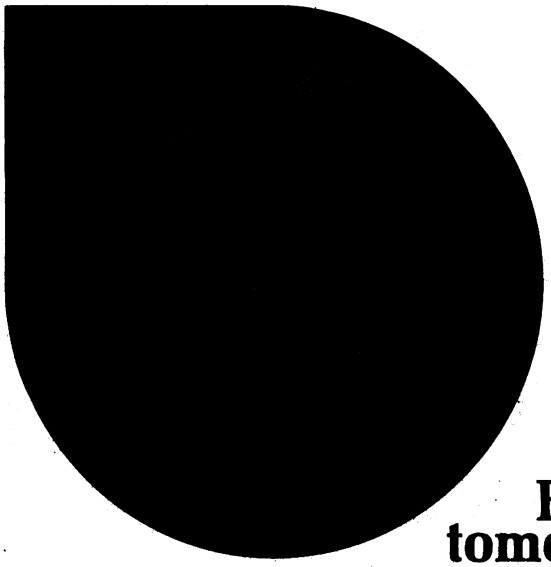
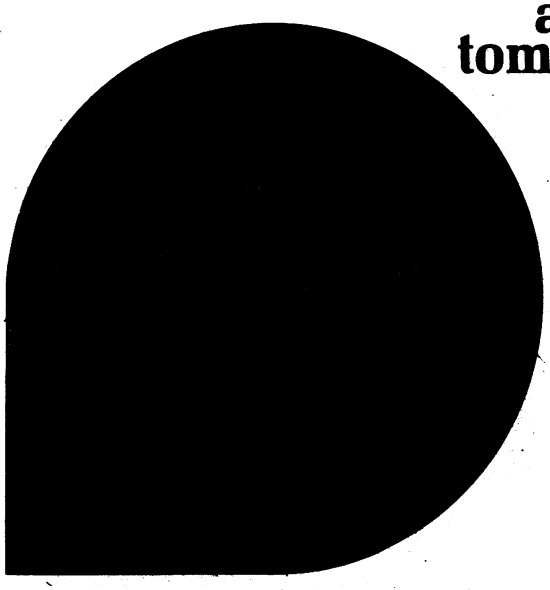
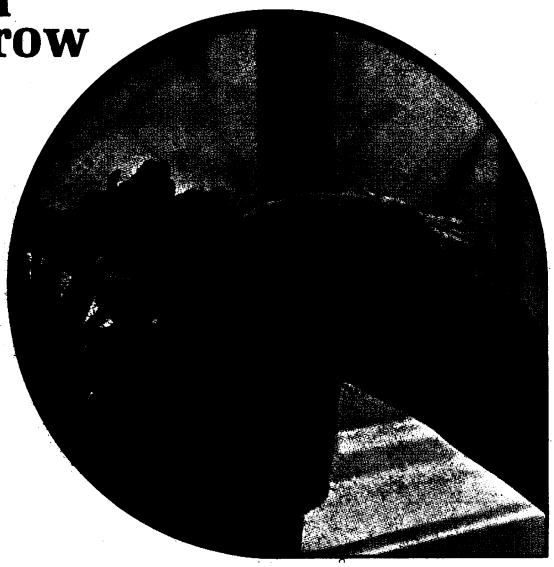
RECOMMENDED DOSAGE *Severe menopausal symptoms* — 1.25 mg daily. If a satisfactory response is not obtained after 3 or 4 days, dosage should be increased to 2.5 or 3.75 mg daily. *Mild or moderately severe menopausal symptoms* — 1.25 mg daily. In some patients 0.625 mg daily will suffice. *To facilitate cyclic therapy, PREMARIN Prem-Paks (1.25 mg or 0.625 mg) provide 4 x 21-day supplies of PREMARIN in circular turn-pack dispensers. Senile vaginitis, kraurosis vulvae, and pruritus vulvae* — 1.25 to 3.75 mg daily or more, depending upon the tissue response.
CAUTION: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1-week rest period — withdrawal bleeding may occur during this 1-week rest period).
CONTRAINDICATIONS: Estrogens are generally contraindicated in patients with a known malignancy or with a strong family history of cancer.

*T.M. Reg'd



For tomorrow, tomorrow, and tomorrow





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(ENTERIC-COATED ACETYLSALICYLIC ACID)

"Only if (acetylsalicylic acid) fails or produces toxic effects are other substances tried," declares Hart.[1]

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As Beaver[2] remarks, "enteric-coated preparations are totally dependent for their value on successful pharmaceutical formulation."

For many years, now, Frosst has been accumulating experience with ENTROPHEN, and constantly checking and testing the product to make sure that ENTROPHEN is indeed "successful".

DOSAGE: A *minimum* therapy for adults may be considered to be 10 grains four times a day. Intermittent therapy is ineffective.

SIDE EFFECTS: Tinnitus, nausea, vomiting, diarrhea. Idiosyncrasy to acetylsalicylic acid can occur, being manifest as skin rash but rarely as anaphylaxis.

Bottles of 100 and 500. **10 gr.** or **5 gr.** tablets. *Full information on request.*

References: 1. Hart, F.D.: Control of Pain in the Rheumatic Disorders. Brit. med. J. **3**:635-640 (Sept. 14) 1968. 2. Beaver, W. T.: Mild Analgesics in the Treatment of Pain. Mod. Treatm. **5**:1094-1119 (p. 1099), (Nov.) 1968.

*Patented 1959

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Some he can't forget...

And some make him forget everything else...

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COMPOSITION: *Anusol Suppositories and Ointment* contain Bismuth Oxide .875%, Resorcinal .875%, Balsam Peru 1.80%, Zinc Oxide 11.0%, Bismuth Subgallate 2.25%, Benzyl Benzoate 1.20%, Cacao Butter Ointment Base q.s. 100%.

Anusol HC Suppositories and Ointment contain the Anusol constituents plus Hydrocortisone Acetate 10 mg. per suppository; 0.25% in ointment.

Anugesic HC Suppositories contain Pramoxine Hydrochloride 25 mg., Hydrocortisone Acetate 5 mg., Bismuth Oxide 23 mg., Bismuth Subgallate 53 mg., Zinc Oxide 278 mg., Balsam Peru 46 mg., Benzyl Benzoate 30 mg., Base q.s. 2.81 gm.

Anugesic HC Ointment contains Pramoxine Hydrochloride 1.0%, Hydrocortisone Acetate 0.5%, Bismuth Oxide 0.875%, Bismuth Subgallate 2.25%, Zinc Oxide 10.75%, Kaolin 0.925%, Balsam Peru 1.875%, Benzyl Benzoate 1.25%, Base q.s. 100%.

ADMINISTRATION: Apply ointment or insert one suppository rectally morning and night for 3 to 6 days or as directed.

CONTRAINDICATIONS: Should not be used in patients with a sensitivity to any of the components.

Full information is available on request.

WARNER-CHILCOTT LABORATORIES CO. LIMITED,
Toronto, Canada

Continuing Searle research now brings you

Demulen®

LOW ESTROGEN ORAL CONTRACEPTIVE

estrogen—50 mcg.
predictable cycle control
clinically proven effectiveness

Reduction of the hormone content of oral contraceptives to the minimum effective level has been a goal of Searle research for over 16 years. This continuing refinement has now led to DEMULEN.

The efficacy of Demulen was established in clinical trials started 3 years ago. No pregnancies occurred in 1,767 women taking Demulen over 11,913 cycles. This low-dose, low-cost, low estrogen oral contraceptive is suitable for most patients.

Switching patients to Demulen from other combination products presents no problems. Your patient should normally finish her current pack of oral contraceptives, wait seven days, and then start on Demulen. No other contraceptive precautions are necessary, even during the first weeks of tablet taking.

Demulen®

Each round, white unscored tablet contains:

Ethynodiol diacetate . . . 1 mg.
Ethinyl estradiol . . . . 0.05 mg.

In Compack® dispensers of 21 tablets. Boxes of 5.

SEARLE

Where "The Pill" Began

modern general practitioner or family physician in terms of his community and hospital function.

4. In a Metropolitan Toronto population of two million, just under 700 general practitioners have been identified. This ratio of one GP to 2,800 population is somewhat below the Canadian average. Possible explanations are:

(1) A considerable number of general practitioners in Metropolitan Toronto were not identified.

(2) Primary care is not as available in Toronto as it is elsewhere in Canada.

(3) More primary care is being delivered by sources other then general practitioners, e.g. directly by specialists, by auxiliary personnel, by the emergency departments of teaching hospitals, or by general practitioners and others whose offices are outside of the Metropolitan boundaries.

5. Most of the general practitioners replying to the inquiry about direct access claimed in a ratio of almost two to one that their practices were open and that they were accepting some new patients.

6. The majority of general practitioners in Toronto graduated from the University of Toronto. A total of 84.3 percent graduated from Canadian, American, British or Irish Universities. Thirteen percent graduated from European Universities. Arranged according to decades, the largest group of GPs has been in practice between ten and 20 years. Just over one third belong to the Academy of Medicine and over half claim to belong to the College of Family Physicians of Canada. Fifty five percent are available for obstetrical care.

7. Proficiency is claimed by the GPs in 30 languages other than English, the most frequent being German, French, Italian, Polish and Russian. A total of 126 physicians claimed proficiency in two or more languages other than English.

8. Only four percent of the GPs claimed to have no hospital connection. But 56 percent claimed affiliation with one hospital and 40 percent with two or more. Many GPs throughout the Metropolitan area maintained an affiliation with downtown teaching hospitals. The older established general hospitals, the Toronto East General and St. Joseph's, and as well the Mt. Sinai tend to draw affiliation on a wide regional basis. The smaller district hospitals are mostly peripheral and recently-established. They tend to command affiliation on a district rather than a regional basis.

Summary

The factors are described which culminated in the production of a Register of General Practitioners in Metropolitan Toronto. The GPs were identified by questionnaire and arranged first by alphabetical list, and then according to district accompanied by suitable maps showing the office location. Also set out were the doctor's availability for new patients; his university and year of graduation; his Academy, College of Family Physicians, and hospital connections; whether he was available for obstetrical services; and languages spoken other than English. Voluntary and official organizations came forward to support the production of the Register because of apparent community need.

The total number of GPs identified (690) indicates that this segment of the profession still supplies a very large amount of primary medical care in Metropolitan Toronto, perhaps of the order of five million patient contacts annually.

A considerable majority of the GPs claimed to be accepting new patients. Most were trained at a Canadian University, had been in practice 20 years or less, did not belong to the Academy of Medicine, did belong to the College of Family Physicians of Canada and were available for obstetrical services. A total of 96 percent claimed an active affiliation with one or more hospitals. A substantial number spoke one or more languages in addition to English. ◀

References

1. Pollard, J.H., et al: Metropolitan Toronto Department of Emergency Services, Report 1967.

2. Clute, K.F., The General Practitioner, University of Toronto Press Toronto, 1963, p. 257.

3. Seywerd, H., et al: Metropolitan Profile, Social Planning Council of Metro Toronto, 1966, p. 36.

NEO-MEDROL ACNE LOTION
the proven professional product for the control of acne vulgaris

Proven effective in clinical trials

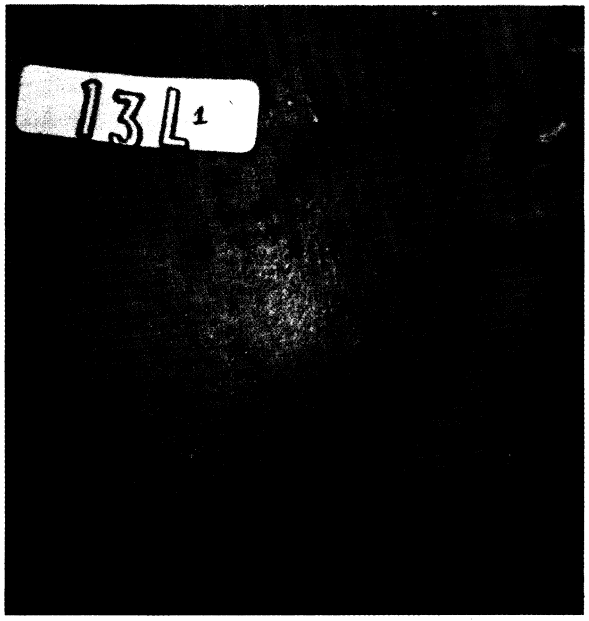
- In 15 clinical studies with Neo-Medrol Acne Lotion, satisfactory responses were reported in 87.5 percent of the acne vulgaris cases treated. A total of 835 patients were involved in the trials.

Accepted widely by both male and female patients

- Neo-Medrol Acne Lotion keeps acne under control.
- The lotion is invisible when dry and may be worn under makeup.

Economical to use

- A 60 cc. bottle of Neo-Medrol Acne Lotion provides a generous supply of medication and is especially economical when large areas are involved or when prolonged maintenance is required.
- The lotion spreads easily and smoothly to provide maximum coverage.



Acne vulgaris, before treatment

After four weeks' therapy with Neo-Medrol Acne Lotion

Neo-Medrol Acne Lotion

the professional answer to the problem of acne

Each cc. contains:

Medrol (methylprednisolone) acetate	2.5 mg. (0.25%)
Neomycin sulphate (equivalent to 1.75 mg. neomycin base)	2.5 mg. (0.25%)
Sulphur (from colloidal sulphur)	50 mg. (5.0%)
Aluminium chlorhydroxide complex	100 mg. (10.0%)

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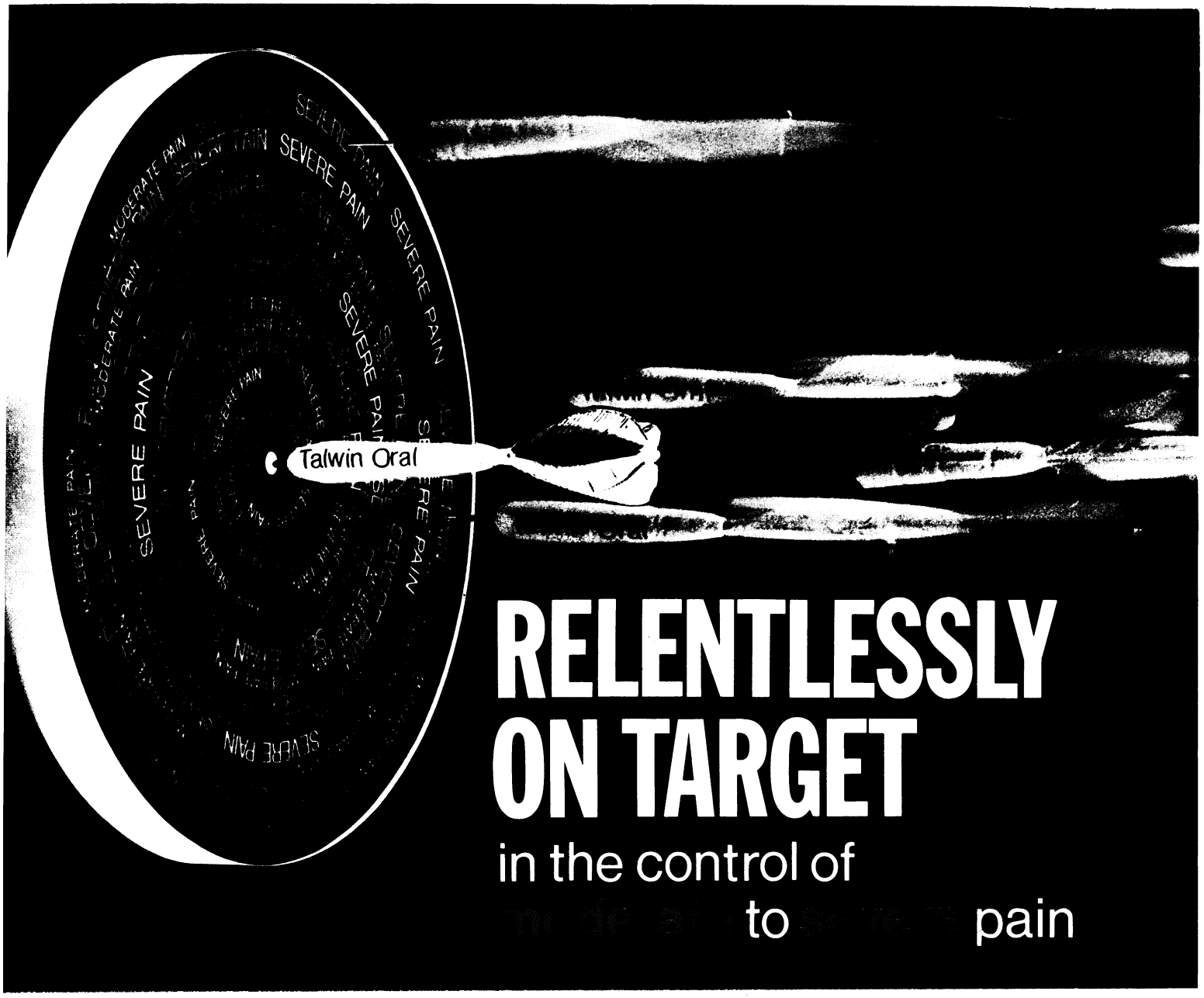
Upjohn

THE UPJOHN COMPANY OF CANADA/DON MILLS, ONTARIO

Administration: Apply sparingly to the affected area once or twice a day. Most patients find the once-a-day application sufficient.

Supplied: 30 cc. and 60 cc. plastic squeeze bottles.

Cautions: Should not be used in the presence of cutaneous infections due to organisms for which specific therapy is not available. Avoid contact with the eyes. Detailed information is available upon request.



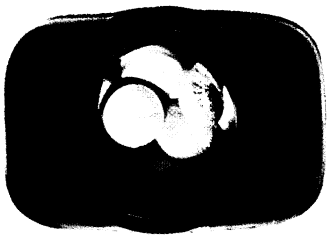
RELENTLESSLY ON TARGET

in the control of

to pain

NEW TALWIN ORAL 50 mg.

(brand of pentazocine HCl)



- A potent Oral Analgesic . . . a 50 mg. dose appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine.
- For acute and chronic pain.
- Acts rapidly — usually between 15 to 30 minutes.
- Non-narcotic.
- May be used for as long as pain persists.
- Tolerance to the analgesic efficacy of TALWIN does not develop.

One tablet every 3 to 4 hours.
Increase to two tablets if necessary.

TALWIN T.M. reg'd Canada. Full information available on request.

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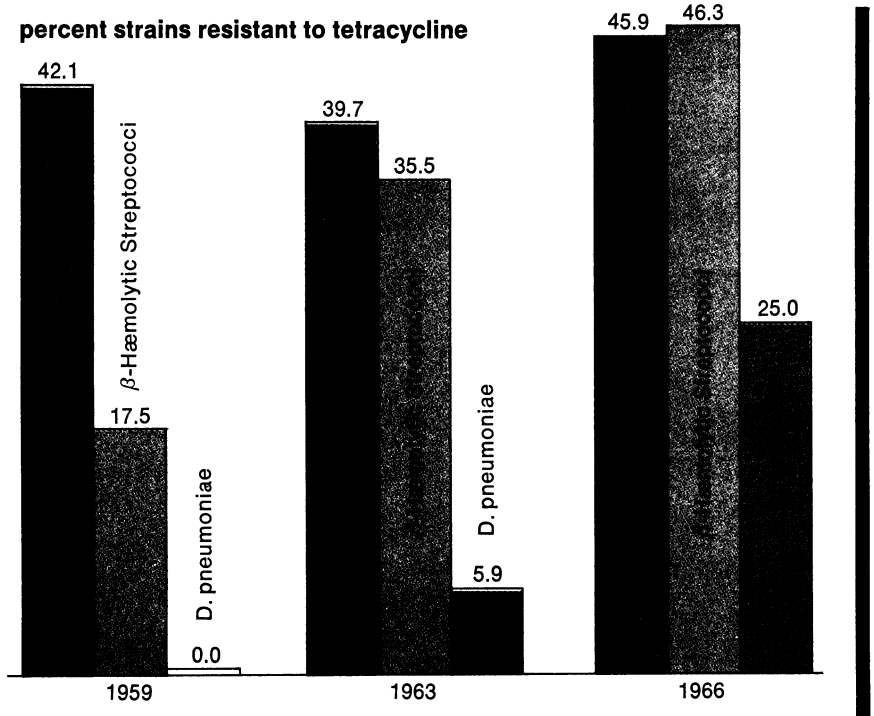
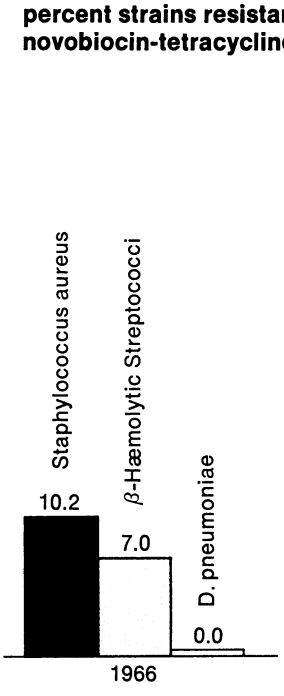
AlbamycinT

antibiotic sensitivity studies show an increasing development of organisms resistant to tetracycline; the addition of novobiocin to tetracycline overcomes this.





"A combination of novobiocin with tetracycline allows minimal novobiocin resistance development and virtually eliminates tetracycline resistance development."[4]

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Effectiveness and safety make Orinase® easy to prescribe

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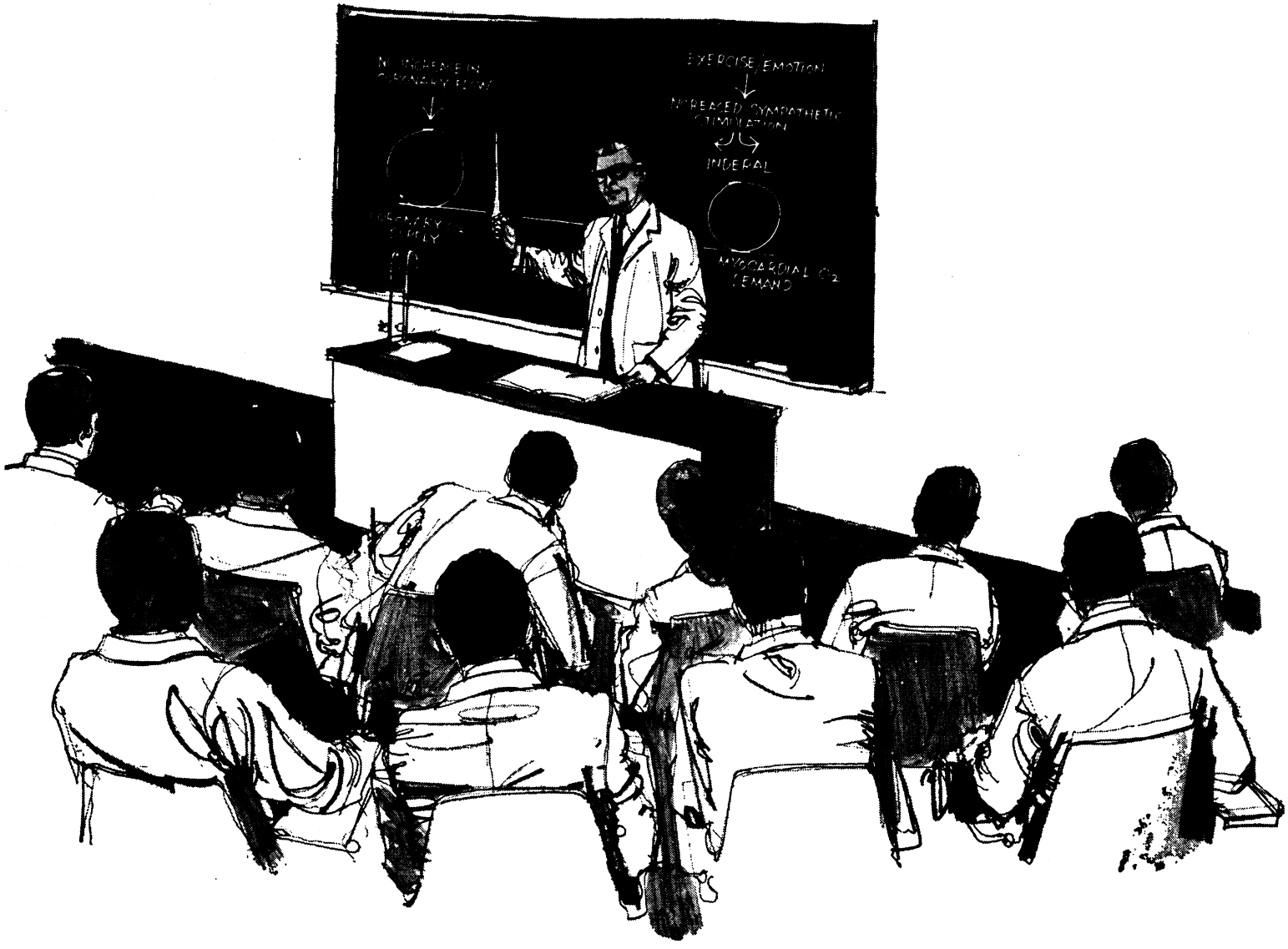
WORLD LEADERS IN DIABETES RESEARCH

"...and the newest drug for effective prophylaxis and control of angina pectoris is propranolol hydrochloride – better known by its trade name, **Inderal***"*



Inderal introduces into clinical practice the first beta-adrenergic receptor blocking agent and offers a completely new approach in the treatment of angina pectoris, cardiac arrhythmias, the management of hypertrophic subaortic stenosis, and pheochromocytoma.

Hamer and Sowton, Birkett and Chamberlain, Conn and Bruce, and Mizgala et al have demonstrated that Inderal, given intravenously or orally to patients exercising on a bicycle or treadmill, prevented or delayed anginal attacks. Inderal also increased the patients' capacity to work at

"Then a real therapeutic value can be attributed to ***Inderal?"***

"Most certainly! ***Inderal*** *increases patients' capacity for work or play, reduces requirements for nitroglycerin, and reduces the incidence and severity of anginal pains."*

a lower heart rate than during control exercise periods.

Moreover, numerous controlled double-blind trials have proved that Inderal, in appropriate oral doses, resulted in statistically significant benefits compared with placebo medication. Many patients reported decreased anginal attacks, decreased nitroglycerin requirements and increased physical activity. Patients also exhibited a slower pulse rate, generally without affecting blood pressure. These changes were often reversed when patients were transferred to placebo medication.

The degree of benefit was proportional to the dosages, which ranged from 40 mg to 400 mg per day, orally in divided doses. Complications were less frequent than expected and responded to the usual therapeutic measures.

"So, this is the most dramatic advance in the long-term treatment of angina pectoris."

"Yes, I believe it is."

Inderal*

AYERST LABORATORIES

division of Ayerst, McKenna & Harrison Ltd.
Montreal, Canada

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Complete prescribing information and references available on request.

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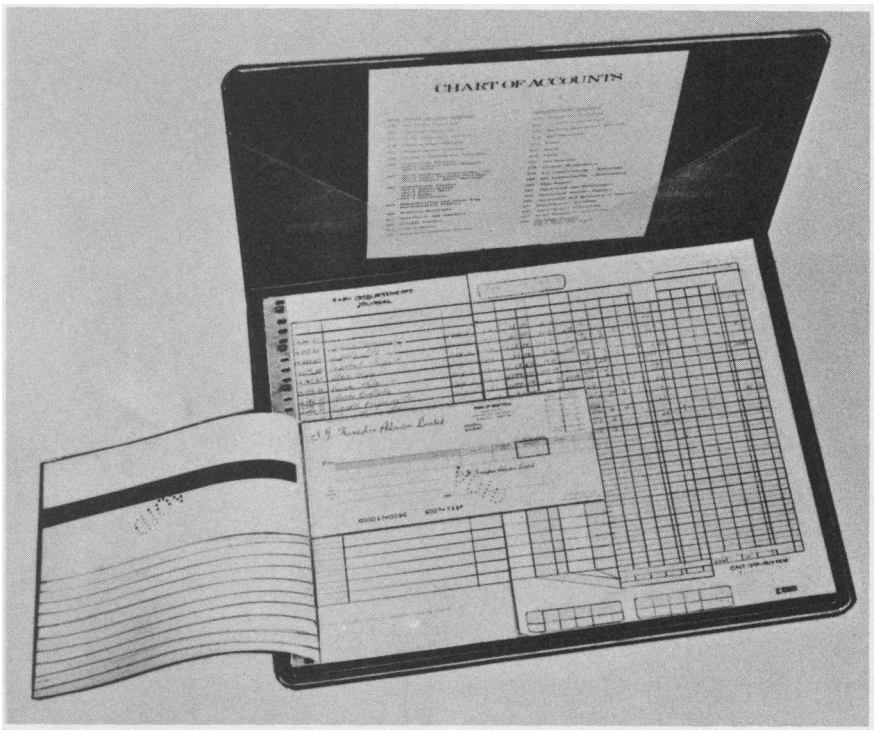
*T.M. Reg'd

M-2522/4/70

New Products

SystemFold DataBoard for EDP Input

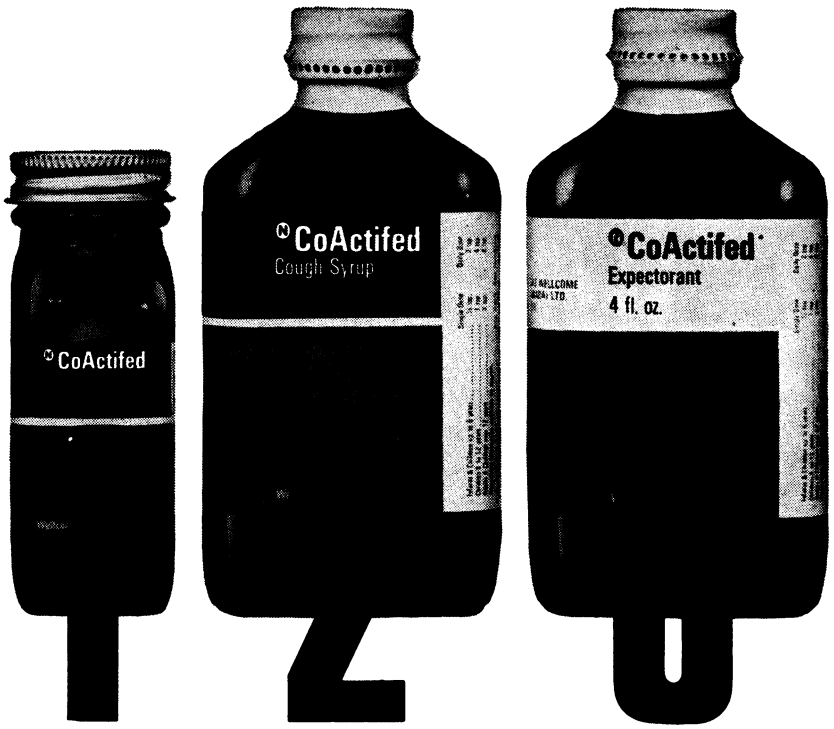


For those physicians whose accounts are computerized, Systems Equipment Ltd. introduce the SystemFold DataBoard, which, when used in conjunction with the company's One Writing Disbursement System, is designed to reduce clerical work when submitting data for EDP input. Cheques are written and accounted for at the same time and daily account totals are available. At audit time, claim the manufacturers, there is a clear record of accurate accounts, with no recopying needed.

For further information: Systems Equipment Ltd., 1595 Buffalo Place, Winnipeg 19, Man.

Statements made in this section of CANADIAN FAMILY PHYSICIAN *are taken from material provided by the manufacturers or distributors concerned, and imply no endorsement of the products. Readers interested in any of the items should contact the companies concerned.*

comprehensive cough control is as easy as



CoActifed tablets **CoActifed syrup** **CoActifed expectorant**

An effective cough control preparation, CoActifed combines a decongestant and an antihistamine with the added cough suppressant effectiveness of codeine. It's available as syrup, tablets or expectorant. CoActifed is available by prescription only, although of course, with the convenience of being able to telephone your prescriptions to the druggist. It's the truly *professional* cough control preparation, extremely effective for *all* common coughs and particularly ideal for coughs resulting from the common cold, flu, allergic asthma and acute bronchitis. CoActifed . . . it's good medicine!

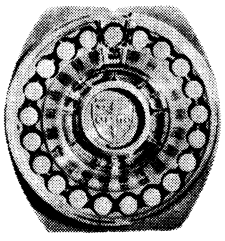
CoACTIFED* SYRUP EXPECTORANT TABLETS

Burroughs Wellcome & Co. (Canada) Ltd.

*Trade Mark

ORTHO-NOVUM 1/50* TABLETS

A reassuring combination for you and her



ORTHO-NOVUM 1/50 has an estrogenic content of 50 mcg of mestranol. This provides the *lowest estrogenic activity* [1-3] *available in oral contraceptive formulations.*

The progestin content of ORTHO-NOVUM 1/50 is 1 mg of norethindrone, a progestin used in oral contraceptive formulations for over 14 years. This long period of use provides an excellent measure of reassurance.

All things considered, when you have a patient who you feel will do well on "the pill," it makes sense to start her on the combination that provides the lowest estrogenic activity with a time-tested progestin.

1. Martinez-Manautou, J. and Rudel, H. W.: in Ovulation, R. B. Greenblatt (Ed.), J. B. Lippincott, Philadelphia, 1966, p. 243. 2. Kupperman, H. S. *et al.*: Pharmacologic Properties and Clinical Effects of Estrogen in the Human, Exhibit, The Wilson Research Foundation, Inc., New York City. 3. Delforge, J. P. and Ferin, J.: A histometric study of two estrogens: ethinylestradiol and its 3-methyl-ether derivative (mestranol); their comparative effect upon the growth of the human endometrium, Contraception 1:57, Jan. 1970.

Book Reviews

Title: **The Hard of Hearing Child**
Author: Frederick S. Berg and Samuel G. Fletcher
Publisher: Longmans Canada Limited
Price: $14.70
Pages: 363

This book is well-written and the publishers have done a creditable job in its preparation. However, the book could have been more attractively bound and the quality of the paper, as well as the type size, could have been more attractive to the advantage of the reader.

The Hard of Hearing Child reads like a textbook, which indeed it is. The authors state in the preface that it is designed as a tool for action and a ready reference for clinical centers, students and parents. I agree with this but parents would have a difficult task in understanding the technical language.

The only part of this book which would be of value to the family physician is the last, and only portions of this section will add to his knowledge. The book is divided into three parts: the first section is interesting in that it reviews the history and incidence of the hard of hearing child. The second section is a basic anatomical and physiological statement of the problem. In the third section the team approach to the treatment of this condition is expounded. This is the approach to problem solving that the general physician has been using and we are all familiar with this method. However, some new concepts are introduced that I found interesting and informative.

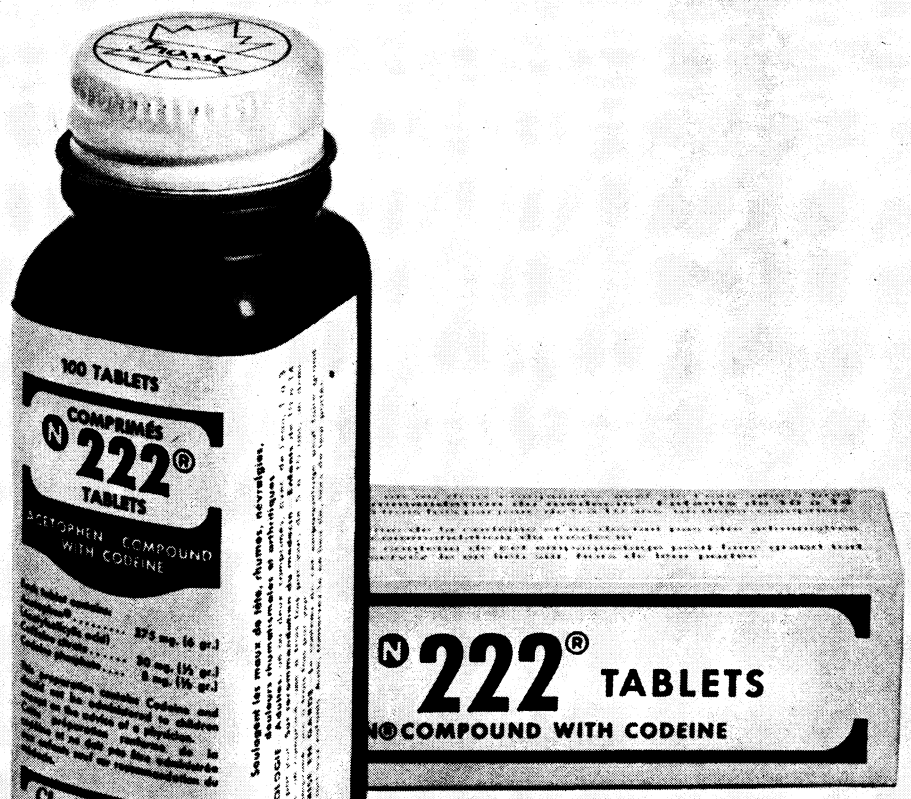
At the outset I expected to read a very dull textbook. By the time I had completed the book I found I enjoyed it. While it was interesting it did not however add much to my knowledge which would have any real application to my practice. I would recommend this as a good book to have in the library of a teaching and research center but it would have a minimal use in the smaller hospital library.

Reviewed by W. P. Fraser, MD. (Dr. Fraser is in family practice in Galt, Ont.)

Title: **First Offender**
Author: Joe Alex Morris
Publisher: Longman Canada Ltd.
Price: $3.95
Pages: 214

This moderate-sized paperback deals in considerable detail with a program initiated in 1959 by Judge Leenhouts in Royal Oak, Michigan. Very soon after his appointment as judge of a lower court he realized that conviction and punishment for minor offences had little effect on the individual and that repeat appearances in court were common. He also was well aware of the fact that few major crimes were committed by individuals who did not have a record of minor offenses.

Faced with the problem of lack of trained probation officers and lack of money, he turned to local volunteer talent and asked for help from six people in the community. Eight



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To conform with current medical teaching, 222® Tablets are now formulated **without phenacetin.**

A corresponding amount of acetylsalicylic acid has been added in order to maintain the same dependable analgesia expected of 222 Tablets.

Each tablet now contains:
Acetylsalicylic acid 375 mg. (6 gr.)
Caffeine citrate 30 mg. (½ gr.)
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Dosage: One or two tablets as needed.
Contraindications: Salicylate sensitivity, peptic ulcer.
Side effects: Skin rash, gastrointestinal bleeding, headache, nausea, vomiting, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, and thirst may develop with average or large doses.
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Important Announcement -

From the Original Developers of Isoproterenol

Dear Doctor,

Last September, we introduced Alupent tablets, a major advance in the long-term treatment of bronchospastic disorders. Today, we take great pride in announcing the availability of

Alupent® Metered Aerosol and Alupent® Solution 5%

the only bronchodilator inhalants which offer both immediate and prolonged action of up to 6 hours.

These new dosage forms have been found effective in the treatment of bronchospasm associated with:

bronchial asthma
chronic bronchitis
pulmonary emphysema

but because of their immediate effect, they are particularly useful in relieving the acute attack of bronchospasm.

Alupent has been thoroughly investigated both in Canada and abroad with over 1,000 published references appearing to date in the world literature. When compared to isoproterenol, epinephrine, and ephedrine, Alupent was found to be:

more effective (1, 2, 3, 4)

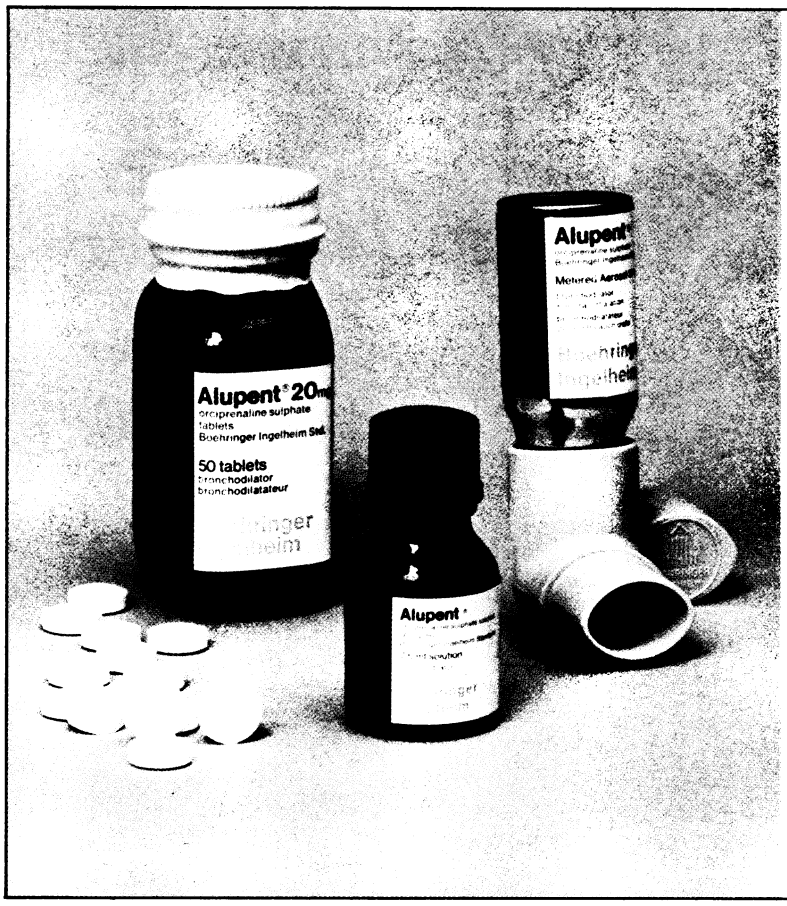
more selective in action (1, 5, 6)

rapid and long-acting (7, 8, 9, 10)

These important advantages substantiate our claim that Alupent is indeed "the first significant chemical advance in bronchodilators in over 25 years." We suggest you evaluate Alupent in your practice - you'll find it to be a superior bronchodilator!

Yours very truly,

M. B. Russo
General Manager



Alupent®
orciprenaline sulphate

Tablets ...
for the long-term management of chronic wheezing patients.

Metered Aerosol ...
for the immediate relief of acute attacks of bronchospasm.

Solution ...
for patients who prefer a wet aerosol spray and for inhalation therapy in hospital.

Description

Alupent is a highly effective bronchodilator/antiasthmatic possessing the following major characteristics:

- Because the beta stimulating action of Alupent is more precise, the ratio of bronchodilating to cardiovascular effects is more favourable with Alupent than with other sympathomimetic bronchodilators such as ephedrine and isoproterenol.
- The efficacy of Alupent after both oral and inhalation administration has been demonstrated by pulmonary function studies (spirometry and measurement of airways resistance by body plethysmography).
- Rapid onset of action follows the administration of Alupent. The effect of aerosol administration is usually demonstrated immediately while the effect of tablets is normally noted within 30 minutes ... peak effect of both forms occurs between 60 to 90 minutes, and the effect persists for 3 to 6 hours.
- The effect of an aerosol bronchodilator may be potentiated by administration of an Alupent 20 mg tablet, 90 minutes prior to use of the aerosol. No additive effect occurs when the drugs are given in reverse order.
- Patients have not developed tolerance to the drug during prolonged therapy.
- No toxic effects on the liver, kidneys or haematologic system have been reported in the long-term use of Alupent.

As with all drugs which are administered for long periods of time, the physician should thoroughly familiarize himself with the indications, contraindications, warnings, precautions, dosage and possible adverse reactions of Alupent.

Medicine's Future: A Student's View

"The Special Article by Dr. Charles F. Code (NEJM Sept. 24, 1970) deserves mention because it typifies the rumors regarding general practice that are spread by researchers and clinicians who have never experienced practice outside a medical center. As a student interested in the new specialty of family practice, I find this most distressing. I have spent ten weeks observing the practices of 14 general practitioners and ten specialists in a community medicine preceptorship and can offer rebuttal based on my experience.

Dr. Code contends that the generalist is overworked and suggests that to solve the problem, we should reduce the number of generalists! This is absurd. The generalist is capable of taking care of many times the number of cases a specialist can (or should). To eliminate him would be like trading buses for VWs to manage our transportation problem.

He proposes that primary care be delivered by mixed specialty clinics. This cannot be done without severely misconstruing the meaning of 'primary care'. He projects that generalists will be reduced to inconsequential proportions in the 1980s, when, in fact, the creation of the Family Practice Specialty Board is increasing interest among students in this career. He suggests that people will be better served by a health care unit "within a radius of 100 miles or more", when most doctors are finally realizing that ghetto families are unable to travel even a few blocks for health care.

He surmises that "the public has accepted the trend (to specialization)" when, in fact, it is clamoring at the doors of our legislature for more "family doctors". Even an intellectually sophisticated group like the Faculty of Duke University, when given a choice between "the present method of specialty care" and "a family doctor", preferred the latter 99 to 2!

As a profession we cannot, as Dr. Code's suggestions would require, gain free time by making ourselves unavailable to our patients. We can lighten the burden on each doctor by making more efficient use of our finite number of doctors and teaching manhours. When 85 to 90 percent of all human ailments do not require specialty skills or knowledge, a system that allows almost all its physicians to discard the ability to deal with these problems and to prepare themselves only for the ten percent of *their specialties* which could not be handled by a generalist, is inexcusably wasteful.

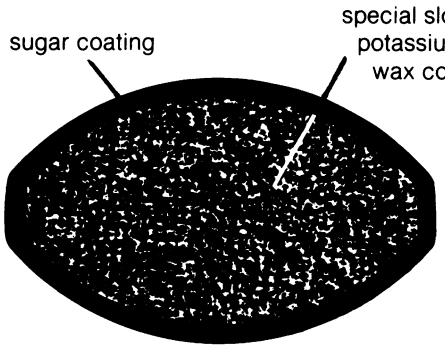
I agree that the medical profession is rapidly changing and the generalist of the 1970s cannot use the approach of the 1940s. He must respond to the needs of the patient, the medical profession and society. The result will be that the family physician of the 1970s will become even more adept at his role as specialist in versatility."

Student's Letter in New England Journal of Medicine, December 17, 1970.

"Slow-K®

(potassium chloride) tablets are the only satisfactory method of giving potassium by mouth."

O'Driscoll, B.J.: *Potassium Chloride with Diuretics.* Brit. med. J. 2:348, 1966.



"The tablets are palatable and do not cause gastric irritation or ulceration of the small bowel."

J. Roy. Coll. Gen. Practit. 15:36, 1968

Slow-K
slow-release potassium chloride tablets

- Slow-K provides a steady K^+ absorption over 4 to 5 hours.
- For the 4-5 hours of Slow-K absorption any underlying K^+ loss is countered, e.g., during diuretic therapy.
- Slow-K tablets are sugar-coated, palatable and easily swallowed.
- Slow-K contains Cl^- ion which is physiologically essential to ensure K^+ absorption and retention in patients with a tendency to develop metabolic alkalosis.
- No bicarbonate in Slow-K which cannot therefore accentuate metabolic alkalosis.
- Slow release of K^+ from Slow-K is less likely to produce hyperkalemia in cases of renal impairment.
- Each Slow-K tablet provides 600 mg. KCl (8mEqK^+) in an easily-taken tablet.
- Slow-K is economical.

INDICATIONS—All circumstances in which potassium supplementation is necessary, and particularly during prolonged or intensive diuretic therapy

Patients at special risk are those with advanced hepatic cirrhosis or chronic renal disease, patients with considerable edema (particularly if urinary output is large), patients on a salt-restricted diet and patients receiving digitalis (a lack of potassium sensitizes the myocardium to the toxic effects of digitalis).

The range of indications for Slow-K may be summarized as follows:

As a supplement to diuretics
Hypochloremic alkalosis
Cushing's Syndrome
Steroid therapy
Liver cirrhosis
Diseases characterized by persistent vomiting or diarrhea
Digitalis therapy
Ulcerative colitis
Steatorrhea
Chronic diarrhea
Regional ileitis
Continuous withdrawal of gastrointestinal fluids
Ileostomy
Neoplasms or obstructions referable to the gastrointestinal tract

DOSAGE—The dosage is determined according to the needs of the individual patient. When administered as a potassium supplement during diuretic therapy, a dose ratio of one Slow-K tablet with each diuretic tablet will usually suffice, but may be increased as necessary. In general, a dosage range between 2-6 Slow-K tablets (approximately 16-48 mEq K+) daily, or on alternate days, will provide adequate supplementary potassium in most cases. Preferably, administer after meals.

Warning—A probable association exists between the use of coated tablets containing potassium salts, with or without thiazide diuretics; and the incidence of serious small bowel ulceration. Such preparations should be used only when adequate dietary supplementation is not practical, and should be discontinued if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.

SIDE EFFECT—Up to December 1970 more than 2500 million tablets of Slow-K and CIBA thiazide tablets containing the slow-release potassium chloride core have been used throughout the world. Only three cases of small bowel ulceration, one of which is of doubtful origin, have been reported.

CAUTIONS—Administer cautiously to patients in advanced renal failure to avoid possible hyperkalemia. Slow-K should be used with caution in diseases associated with heart block since increased serum potassium may increase the degree of block.

CONTRAINDICATIONS—Renal impairment with oliguria or azotemia, untreated Addison's Disease, myotonia congenita, hyperadrenalism associated with adrenogenital syndrome, acute dehydration, heat cramps and hyperkalemia of any etiology. Conditions associated with stasis of the G.I. tract.

SUPPLIED—Tablets (pale orange, coated) each containing 600 mg. of potassium chloride in a slow-release, inert wax core; bottles of 100 and 1000.

C I B A
DORVAL, QUEBEC 1043

problems causing a shortage of young men and women pursuing technical careers is the belief, rightly or wrongly, that the university degree is an automatic passport to success, and that to accept training for a higher national certificate or diploma is only second best. The technical colleges and the institute responsible for medical laboratory technicians, aware of this problem, have persuaded the Department of Health to support a degree level course in medical laboratory technology. The diploma is, for the present, seen as an alternative route to fellowship of the professional body concerned. This surely is the wrong approach to the problem, for as already indicated there is a surfeit of graduates and a severe shortage of medical laboratory technicians. This shortage will continue until we can overcome the psychological inadequacies of the present technical education system; to supplement it by a degree level course is in itself an admission of failure of the present system.

The present and future need is for a highly trained, well educated technical force with an emphasis on technical-ability rather than academic prowess. We must aim at a technical education system designed to attract some of the present university entrants who, although less academic, would not feel or be inferior to their graduate counterparts.

The alternative to a complete revision of the present training system would be to staff our medical laboratories entirely with graduates. With the present surfeit of graduates this would be comparatively easy and is infact taking place in chemical pathology laboratories. However, most pathologists would agree that the properly trained medicallaboratory technician is invariably worth two graduates in terms of work load and technical ability. Perhaps the alternative to the present situation is for a school of medical laboratory technology?"

Physician's letter in the British Medical Journal, December 5, 1970

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effectively

"Premenstrual tension occurs most frequently in women between ages 25 and 40. Its true etiology is unknown, but it may be due to generalized fluid accumulation as a result of Na ion retention caused by increased steroid hormone activity during the latter half of the menstrual cycle."[1]

"... promotion of diuresis to achieve adequate dehydration and consequent relief from symptoms associated with fluid accumulation in this situation is the most rewarding of all treatments devised to date."[2]

A diuretic such as Lasix can relieve water retention which is manifest as breast engorgement, distention of the abdominal wall and slight edema of the face and ankles. The well-established efficacy of Lasix in edematous states makes it the diuretic of choice in the treatment of premenstrual tension.

safely

In the treatment of premenstrual tension with diuretics, electrolyte balance is of paramount importance. In various types of edema, Lasix assures a significantly better electrolyte balance and consistently less potassium loss than the thiazides.[3] Concentration of electrolytes, pH, bicarbonate content, potassium content, duration of diuresis, are all nearer the normal urine values than with the thiazides. The unparalleled safety of Lasix makes it the diuretic of choice in the treatment of premenstrual tension.

predictably

In the treatment of premenstrual tension, Lasix demonstrates a predictable, dose-related action. Because diuresis is complete in 6 hours, dosage schedules can be timed to suit the patient's requirements for work and sleep. The predictable action of Lasix makes it the diuretic of choice in the treatment of premenstrual tension.

(1) Merck Manual Eleventh Edition, pp. 658-659, 1966. (2) Beckman, H.: Dilemmas in Drug Therapy, pp. 275, Saunders, 1967. (3) Mahabir, M. and Laufer, S. T.: Arch. Intern. Med., *124*:1, 1969.

Lasix, the diuretic to begin with . . . and stay with

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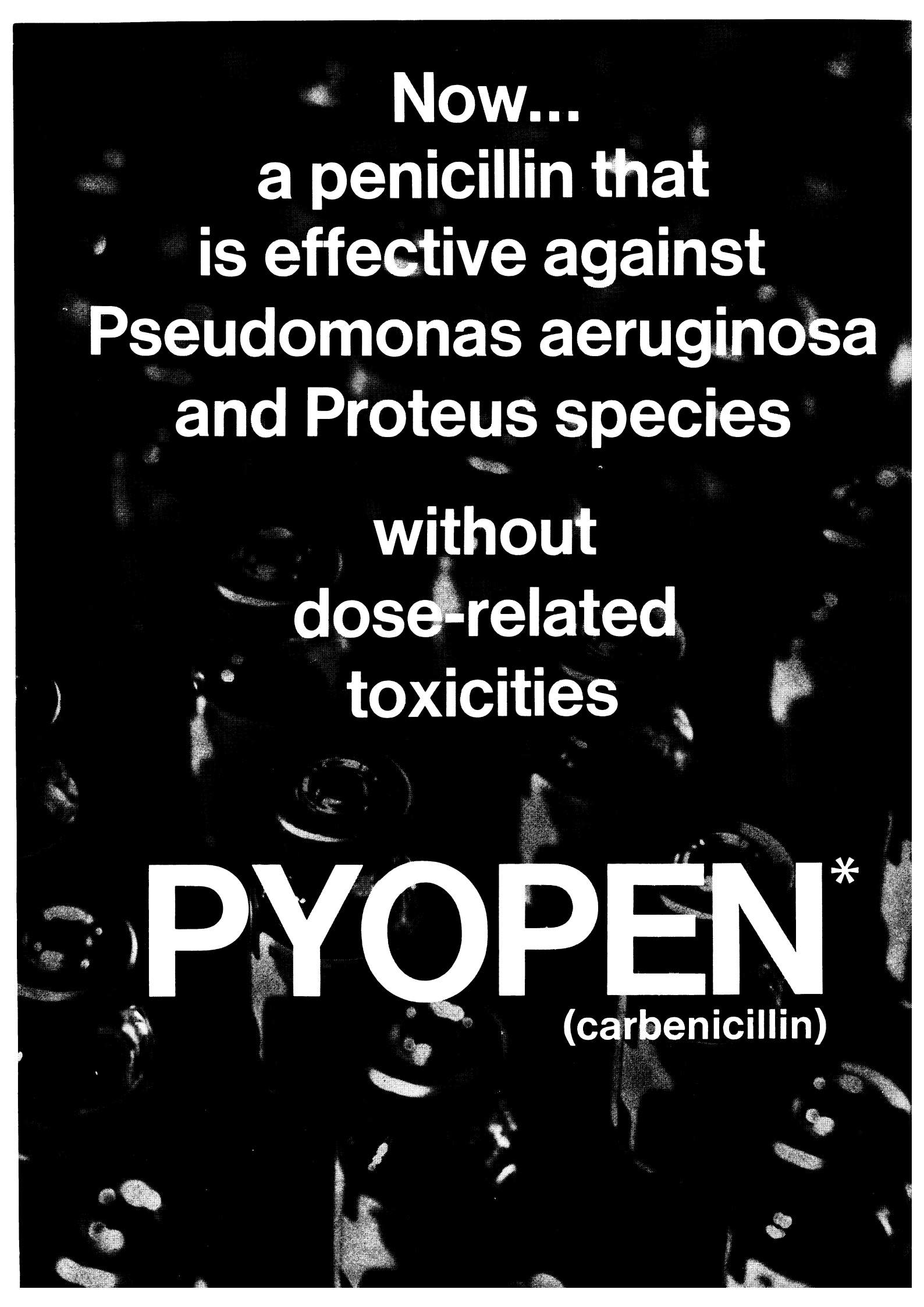

Now...
a penicillin that
is effective against
Pseudomonas aeruginosa
and Proteus species
without
dose-related
toxicities
PYOPEN*
(carbenicillin)

The incidence of infections caused by gram-negative organisms is on the increase — and a majority of these are due to Pseudomonas aeruginosa.

Until the development of PYOPEN, a semisynthetic penicillin, no treatment was available for systemic Pseudomonas infections which did not involve a safety risk of dose-related toxicities.

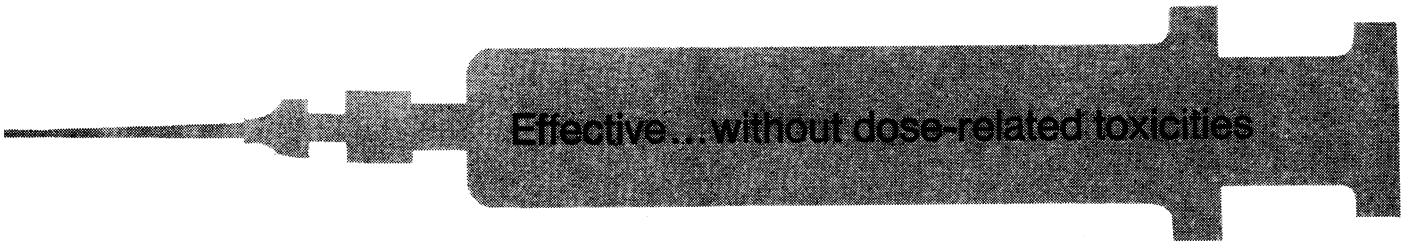
PYOPEN is an important therapeutic advance, providing for the first time the *safety* of a penicillin combined with bactericidal *effectiveness* against Pseudomonas aeruginosa and other gram-negative organisms, particularly Proteus species which are resistant to other antibiotics.

PYOPEN is recommended for severe and overwhelming infections caused by sensitive strains of Ps. aeruginosa and Proteus species (P.vulgaris; P.-rettgeri; P.morganii): septicemia; respiratory tract infections; meningitic infections; urinary tract infections; peritonitis; and infected burns and wounds.

When Pseudomonas aeruginosa and Proteus species are suspected, specify PYOPEN (carbenicillin). It is effective — without dose-related toxicities.

Complete prescribing information and references available on request.

(See next page for brief prescribing information).



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injectable

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5 GM. VIALS

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Ayerst, McKenna & Harrison Ltd.
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*T.M. Reg'd M2576/5/70.

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Help him forget the pain he knows by heart.

Peritrate

The standard in preventive therapy for Angina

Your angina patient can depend on PERITRATE to help provide continuous protection against angina attacks. In regular use, PERITRATE can help him break the undesirable cycle of anxiety → angina → nitroglycerine → further anxiety.

The angina patient often improves markedly as he gains reassurance with this well-tolerated, well recognized agent that helps reduce the frequency and severity of painful attacks.

Prescribe Peritrate (20 mg.) four times daily or Peritrate SA every 12 hours.

Composition:

Peritrate—each tablet contains 20 mg. pentaerythritol tetranitrate, also available as Peritrate with phenobarbital (15 mg.).

Peritrate SA—each two-layered tablet contains 80 mg. pentaerythritol tetranitrate (20 mg. in the immediate-release layer and 60 mg. in the sustained-release base). Peritrate with Phenobarbital SA has in addition 45 mg. of phenobarbital, 15 mg. in the immediate-release layer and 30 mg. in the sustained-release base.

Contraindications and precautions: Peritrate should be used with caution in patients who have glaucoma. Full information is available on request.

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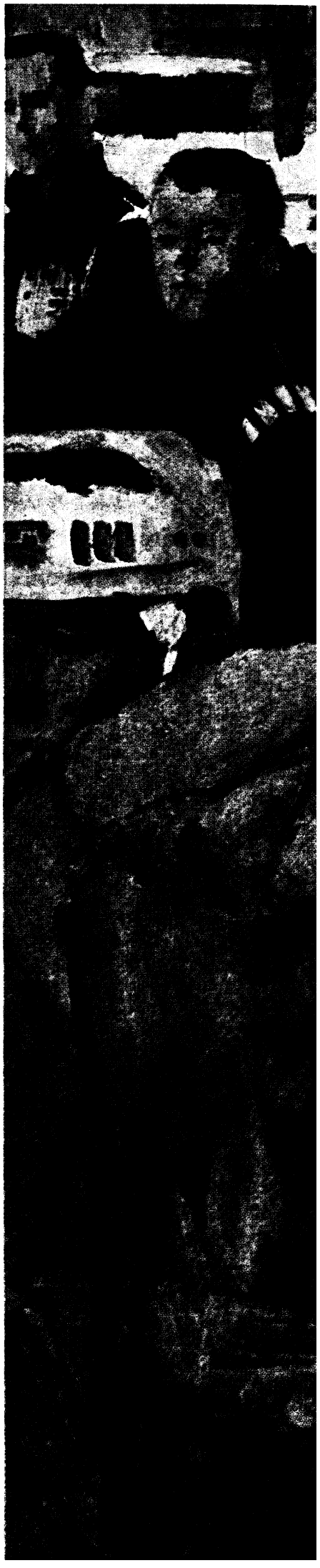
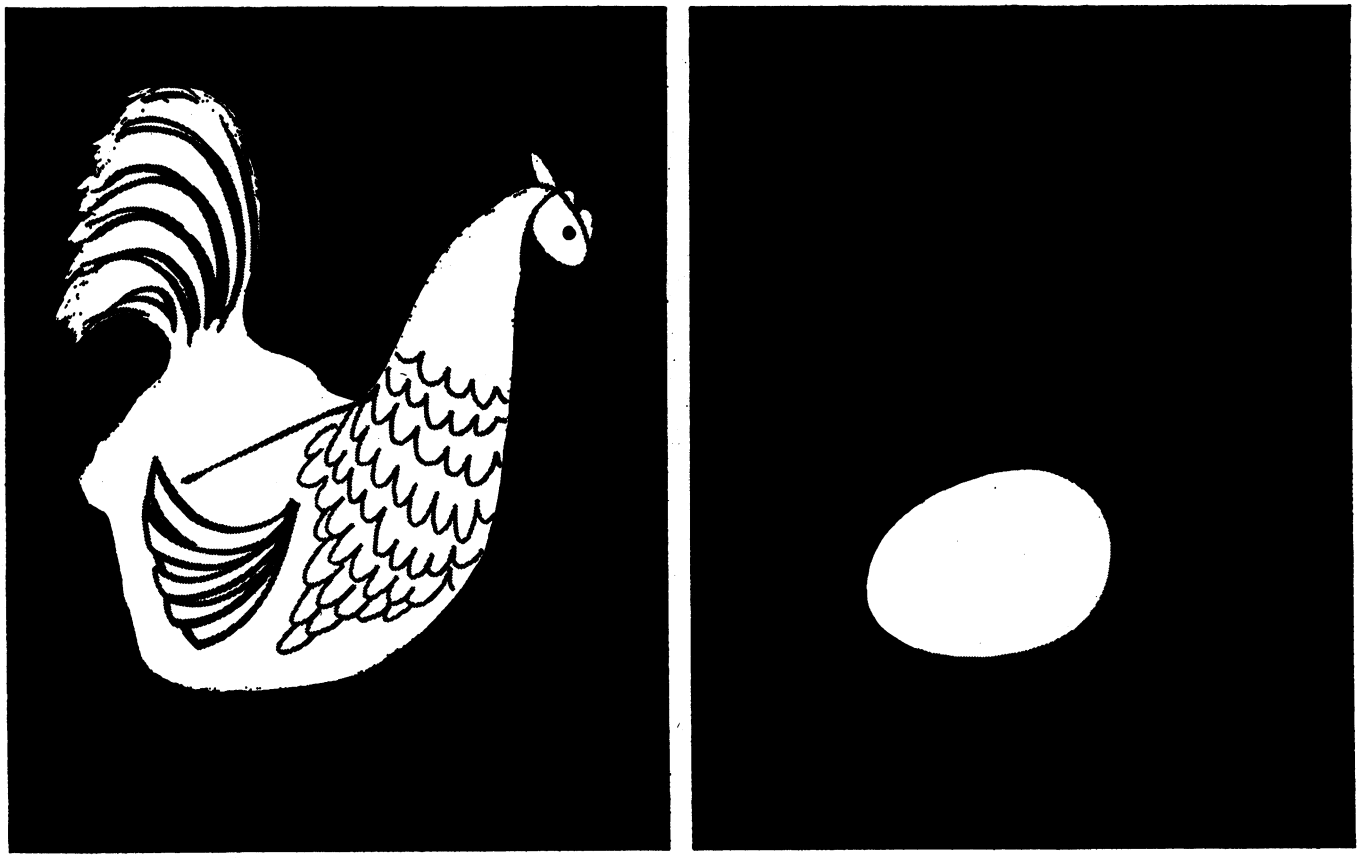


Allergies cause anxiety...

(or is it the other way 'round?)



no matter which comes first

atarax*

restores patient comfort by breaking the anxiety-allergy cycle.

"Atarax . . . is the current drug of first choice in the treatment of resistant cases of chronic urticaria."

Horan, J. D., Vancouver, B.C.; C.M.A.J., Nov., 1965.

Pfizer **PHARMACEUTICAL DIVISION**
50 PLACE CREMAZIE, MONTREAL 351, QUEBEC

SUPPLY: CAPSULES: 10, 25, 50 mg; SYRUP: 10 mg/5 ml hydroxyzine HCl. **DOSAGE:** ADULTS: Up to 100 mg. q.i.d. CHILDREN: Under 6 years: 30-50 mg. Over 6 years: 50-100 mg. Daily, in divided doses. **CONTRAINDICATIONS:** Not indicated in early pregnancy. **PRECAUTIONS:** Possible potentiation of meperidine, opiates, barbiturates, alcohol and other CNS depressants must be considered. Although therapeutic benefits are reported in epileptics on Atarax, in rare cases increase in liability to seizures is observed; also involuntary motor activity in hospitalized patients on high dosages of the drug. **SIDE EFFECTS:** No serious side effects reported. Drowsiness in some patients, but usually transitory. Possible dryness of mouth at higher dosages. Atarax is also available in I.M. solution.
Full prescribing information on request.

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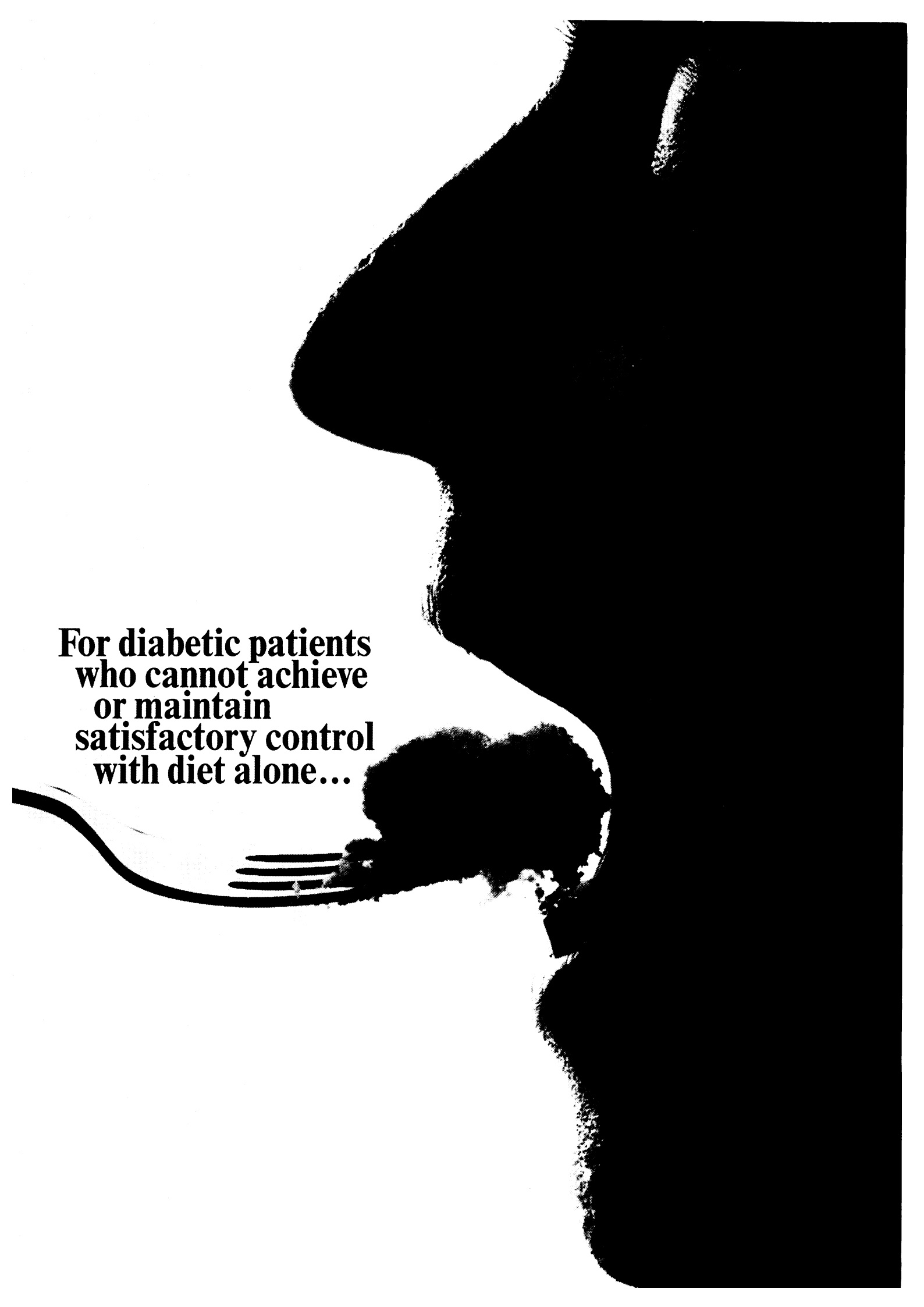
For diabetic patients
who cannot achieve
or maintain
satisfactory control
with diet alone...

recently found no significant difference between indomethacin and acetylsalicylic acid in the treatment of osteoarthritis of the hip.

Our study was carried out to assess the therapeutic efficacy of indomethacin and acetylsalicylic acid in the treatment of acute musculoskeletal disorders. Indomethacin showed statistically significantly lower symptom scores than did placebo at varying times for pain on movement, local tenderness and limitation of movement. Acetylsalicylic acid also showed significantly lower symptom scores for local tenderness and limitation for the same time.

No side effects were noted with the use of indomethacin as compared with acetylsalicylic acid and placebo. Epigastric distress and dizziness occurred in the placebo and aspirin groups in two instances.

No hematological or biochemical changes were detected to indicate that short term therapy of either indomethacin or acetylsalicylic caused pathological changes in the bone marrow, kidney or liver.

The overall evaluation in the treatment of acute musculo-skeletal disorders showed that both indomethacin and acetylsalicylic acid could be

Table III: Duration of Treatment

	Days Until Acute Symptoms Resolved			Days Until Acute Symptoms Resolved		
	Placebo	Acetylsalicylic acid	Indocid	Placebo	Acetylsalicylic acid	Indocid
Median Values	10.0	8.0	9.0	14.0	11.0	13.5
No. of Patients Showing No. Effect	12/32	5/33*	5/34*	13/32	5/33*	5/34*

* Statistically significantly less than Placebo, P<05

Table IV — Physician's Overall Evaluation

	Placebo	Acetylsalicylic acid	Indocid
None = 0	10	5	5
Slight Relief = 1	3	1	0
Moderate Relief = 2	4	2	3
Marked Relief = 3	7	13	12
Complete Relief = 4	8	12	14
TOTAL	32	33	34
MEAN	2.0	2.8*	2.9*

* Statistically significantly greater than Placebo, P<.05

Table V: Side Effects of Drugs

Side Effect	Placebo	Acetylsalicylic acid	Indocid
Epigastric Distress	2/32	0/33	0/34
Dizziness	0/32	2/33	0/34
Total with Side Effects	2/32	2/33	0/34

No statistically significant differences were found.


a
calm mind
deserves
a
calm hand
Phenothiazine and rauwolfia
tranquilizer therapy may cause
extrapyramidal symptoms.
COGENTIN*
(benztropine mesylate, MSD Std.)
AN ANTI-PARKINSONIAN AGENT
for all etiologic groups of parkinsonism
Contraindications: Children under 3 years of age, glaucoma.
FULL INFORMATION AVAILABLE ON REQUEST
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Where today's research is tomorrow's therapy
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(MC-711)

equally useful in the management of these conditions.

Summary

The objective of this study was to assess the therapeutic efficacy of indomethacin and acetylsalicylic acid in the treatment of acute sprains, strains, tenosynovitis, etc., due to injury or accident. Indomethacin showed statistically significantly lower (i.e., better) symptoms scores than did placebo at varying times for pain on movement, local tenderness and limitation of movement. Acetylsalicylic acid also showed significantly lower symptom scores for local tenderness and limitation of movement at some of the same time periods as indomethacin. The physician's overall evaluation showed both indomethacin and acetylsalicylic acid to be statistically significantly better than placebo ($p<.05$). ◀

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Every second and fourth Saturday of the month (September to April), at 10.00 a.m. to 12 noon, alternating between the St. Catharines General Hospital and Hotel Dieu Hospital.

Brantford, Ontario

The second and fourth Thursday of the month (September to May), 8.30 a.m. at the Brantford General Hospital.

Niagara Falls, Ontario

The third Saturday of the month (September to May) at 10.00 a.m. to 12 noon, at the Greater Niagara General Hospital.

Galt, Ontario

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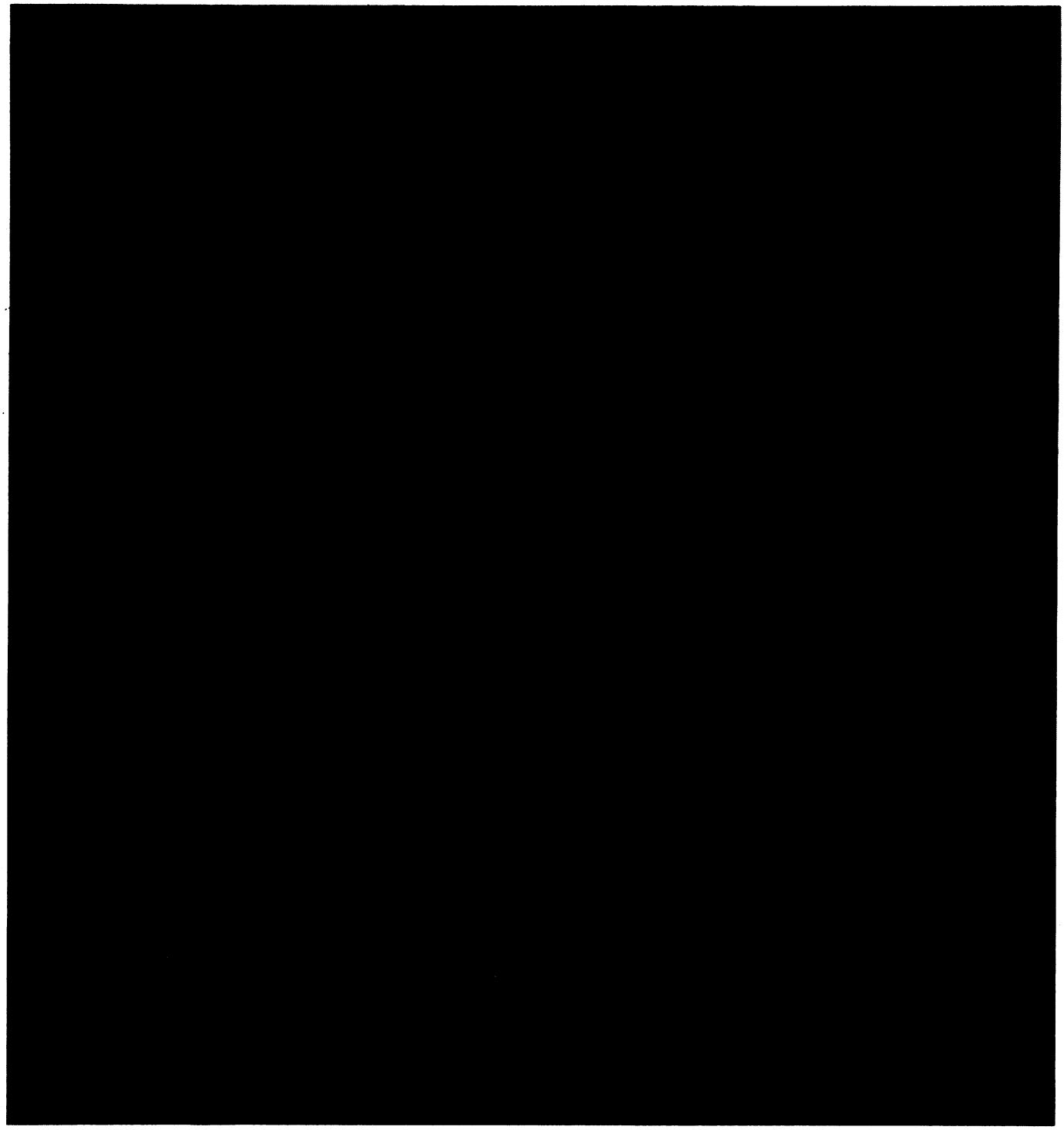

Meuse Delta; Photograph: Courtesy KLM

You've just diagnosed bronchitis.

You've decided to prescribe an antibiotic. You know that the causative pathogen is probably *Haemophilus influenzae,* staphylococcus, streptococcus or pneumococcus. You need an antibiotic that will work quickly with little risk of side effects. An obvious choice: Respiratory Spectrum Erythrocin. Erythrocin's spectrum blankets the organisms most often responsible for bronchial infections. Erythrocin works rapidly, and carries a reassuring 19-year safety record. A dosage form for every patient and every need. Available in Filmtab† tablets 250 mg. Injectable forms and, especially for children, cherry-flavoured Suspension and Drops, Filmtab 100 mg. and Chewable tablets 200 mg. (scored). Also available new Erythrocin Liquid 125 mg. per teaspoonful.

Respiratory Spectrum

℞ Erythrocin*

erythromycin, Abbott

†Filmtab—Film-sealed tablet, Abbott

ABBOTT

See next page for brief summary.

*RD. T.M.

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15th. Annual Scientific Assembly

College of Family Physicians of Canada

BANFF, ALBERTA SEPTEMBER 13-16, 1971

Next Month

The March issue of CANADIAN FAMILY PHYSICIAN is devoted to Psychiatry. Technical articles will include: The Family Physician and the Prevention of Psychiatric Ills by Dr. R. O. Jones; Emotional and Psychosomatic Problems in Family Practice by Dr. G. T. Fiorini; and Dr. Andrew Malcolm's article on the drug scene – The Craving For the High.

In addition, the March issue will feature a review of developments at the University of Saskatchewan in its continuing series on Canadian medical schools, as well as the journal's monthly departments including Comment, Leisure, Reviews, Medical Digest and Practice Management.

Family Medicine Teaching Locums

For physicians who have an interest in teaching family medicine. June, July and August 1971 or any part thereof. Five days per week, second call one night in four and one weekend in four.

Apply:
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Chairman, Division of
Family Medicine,
University of
Western Ontario,
London 72,
Ont.


in arthritis...
Depo-Medrol
for joint benefits
• helps relieve pain
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In rheumatoid arthritis a single intra-articular injection of Depo-Medrol can bring relief from pain within 12 to 24 hours. Relief may last from three to four weeks or longer.
Dosage and Administration: Intra-articular, 10 to 80 mg. depending upon the size of the joint.
Cautions: The usual precautions and contraindications to local corticosteroid therapy should be observed. Detailed information available on request.
Supplied: As methylprednisolone acetate, 20 mg./cc. in 1 cc. and 5 cc. vials, 40 mg./cc. in 1 cc., 2 cc. and 5 cc. vials, and 80 mg./cc. in 1 cc. and 5 cc. vials.
Upjohn
THE UPJOHN COMPANY OF CANADA/DON MILLS, ONTARIO
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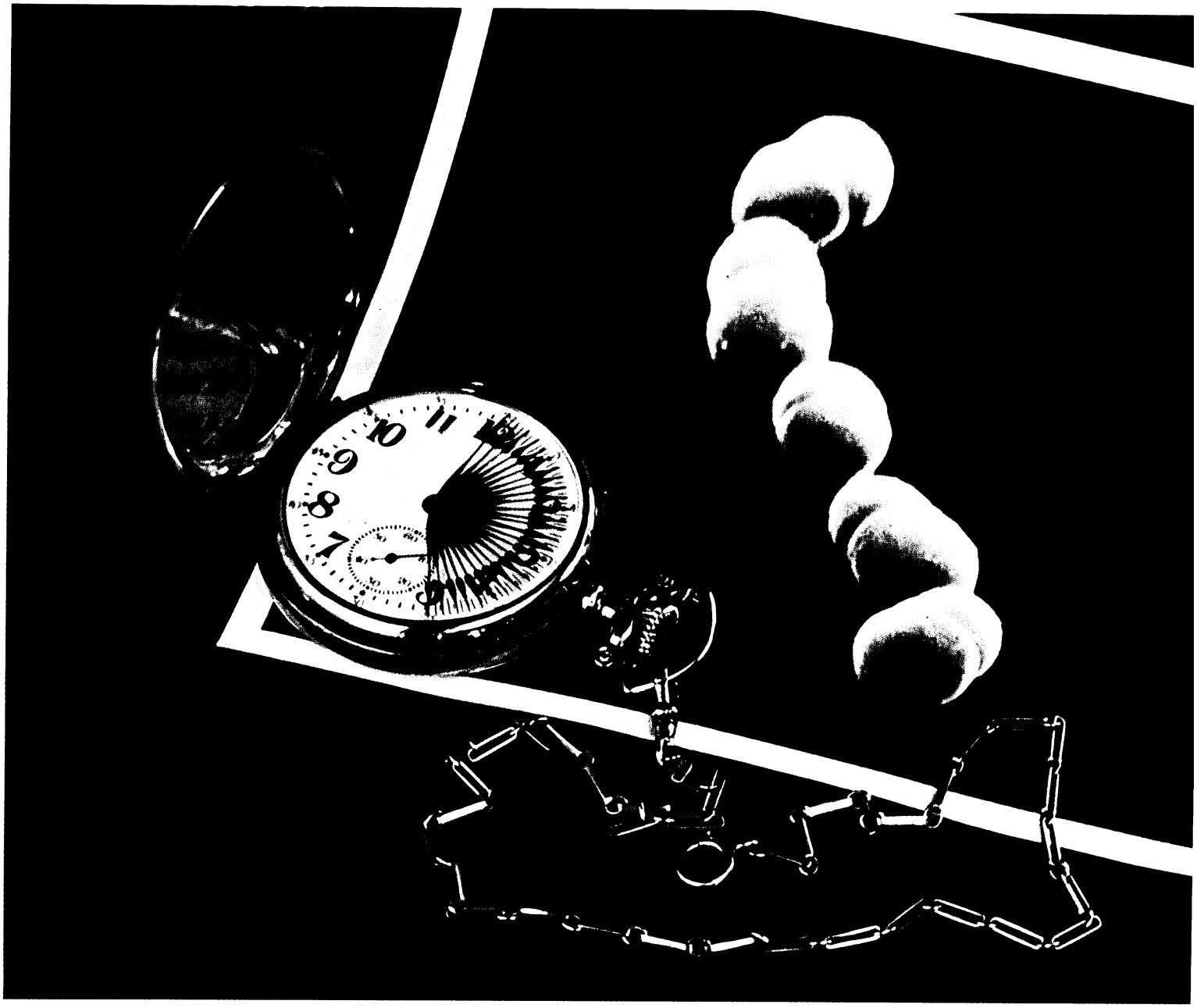


in streptococcal infections

oral

Dalacin C

provides up to 25 times the minimum bactericidal concentration in 25 minutes

As rapidly as 25 minutes after a single dose of Dalacin C, serum levels achieved are up to 25 times the minimum bactericidal concentration for Streptococci.[1] At only 45 minutes from the first dose, antibacterial levels peak, and serum levels continue to be bactericidal until the next dose six hours later.

1. New Drug Application (1968), 9(a) (ii) Table 1, p. 9. Average serum level in twelve patients.

The College of Family Physicians— An Interview With the Executive Director

The College's sophisticated and searching Certification exam will continue to be a major focus of activity. In an interview with CANADIAN FAMILY PHYSICIAN*'s editor, executive director Dr. Donald I. Rice explains this and other aspects of the College – and expresses his views of Canadian family practice, today and tomorrow.*

Woods – *Can you give me a capsule history of the College's development – and some indication of what it is likely to achieve in the next five years?*

Rice – The College was initially conceived to provide a stimulus to family doctors to keep-up-to-date through continuing medical education, and during the early years the College's major activity was directed primarily to this objective. In the interim a good deal of attention has been directed to understanding somewhat better the many factors that contribute to family physicians leaving practice and to what appears to have been until recently a disinterest on the part of medical students to choose family practice as a career.

A study of these factors brought us face to face with the acknowledgment that, as the philosophy of our medical schools changed toward producing basically trained "undifferentiated" doctors, the family practitioner was no longer being trained for his responsibilities in the community. This prompted the College to concentrate on initiating changes at the undergraduate level of medical education that would provide the students with an exposure to the concepts of family medicine and to the family physician as a teacher. To me, the most rewarding development that has taken place in recent years has been the willingness by most of our medical schools to implement these changes. Having introduced the undergraduate student to family medicine, our attention was then directed towards training the family physician at the graduate level as a specialist in family medicine. The promotion of residency training programs in family medicine leading to Certification has now become a major College activity.

During the next five year period, I see a refinement of present training programs in family medicine at both the undergraduate and graduate levels. The present interest on the part of medical students to take residency training in family medicine, together with the interest by family physicians now in practice to become certificated, will continue to make the College's Certification program a major activity.

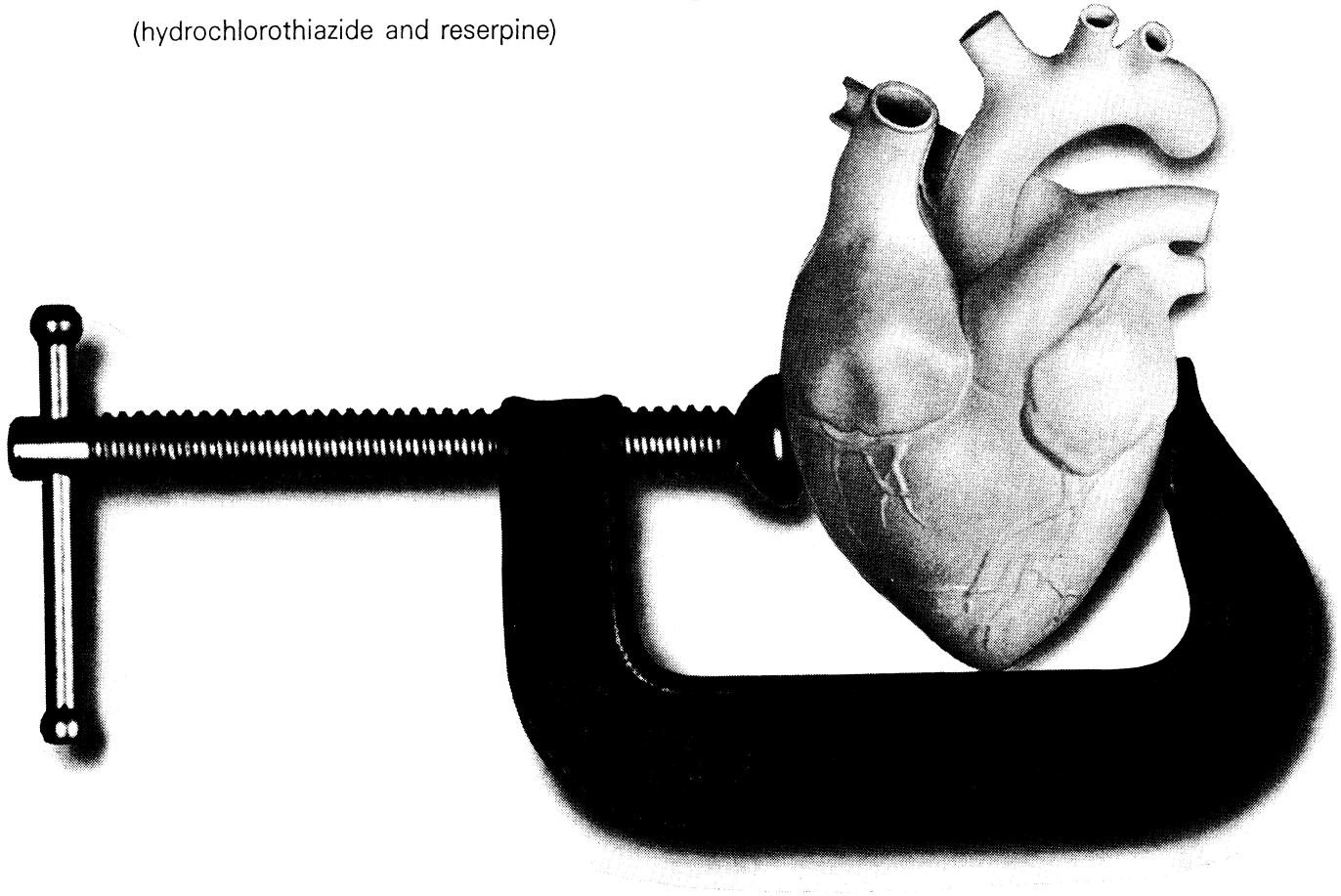
I believe that we will see a major change in the ratio of family physicians to consulting specialists. While it is premature at this time to project current trends an increasing number of medical graduates are choosing careers in family medicine. In several medical schools the numbers represent 60-70 percent of a graduating class. An increase in the number of family physicians trained to work with other health professionals in a group setting will constitute the major change in Canadian medicine during the next five years.

Woods – *The philosophy of Canadian medical schools has been to exclude family medicine from the curriculum. Do you see any evidence that this attitude is changing and, if so, what has been the College's contribution to this change?*

Rice – The change in the philosophy of medical schools during recent years has been dramatic insofar as curriculum is concerned. This change includes the teaching of family medicine by family physician teachers. This change became apparent following two national conferences held in

HYDROPRES*

(hydrochlorothiazide and reserpine)



unwinds the hypertensive pressures

HYDROPRES* is gentle. It is used as first line therapy alone or with other antihypertensive agents for the control of mild to severe hypertension.

HYDROPRES* is a simple preparation—a basic formulation of reserpine and hydrochlorothiazide for a smooth, gentle drop in blood pressure and alleviation of emotional stress.

HYDROPRES* is good starting therapy . . . good maintenance therapy too.

Start with HYDROPRES* and your hypertensive patients may not need anything stronger.

CANADIAN FAMILY PHYSICIAN MÉDECIN DE FAMILLE CANADIEN

OFFICIAL PUBLICATION OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

EDITORIAL THEMES FOR 1971

January
General Medicine (with special reference to rheumatism and arthritis)

February
Pediatrics

March
Psychiatry

April
General Medicine (with special reference to neurology)

May
Obstetrics and Gynecology

June
Pediatrics

July
General Medicine (with special reference to geriatrics)

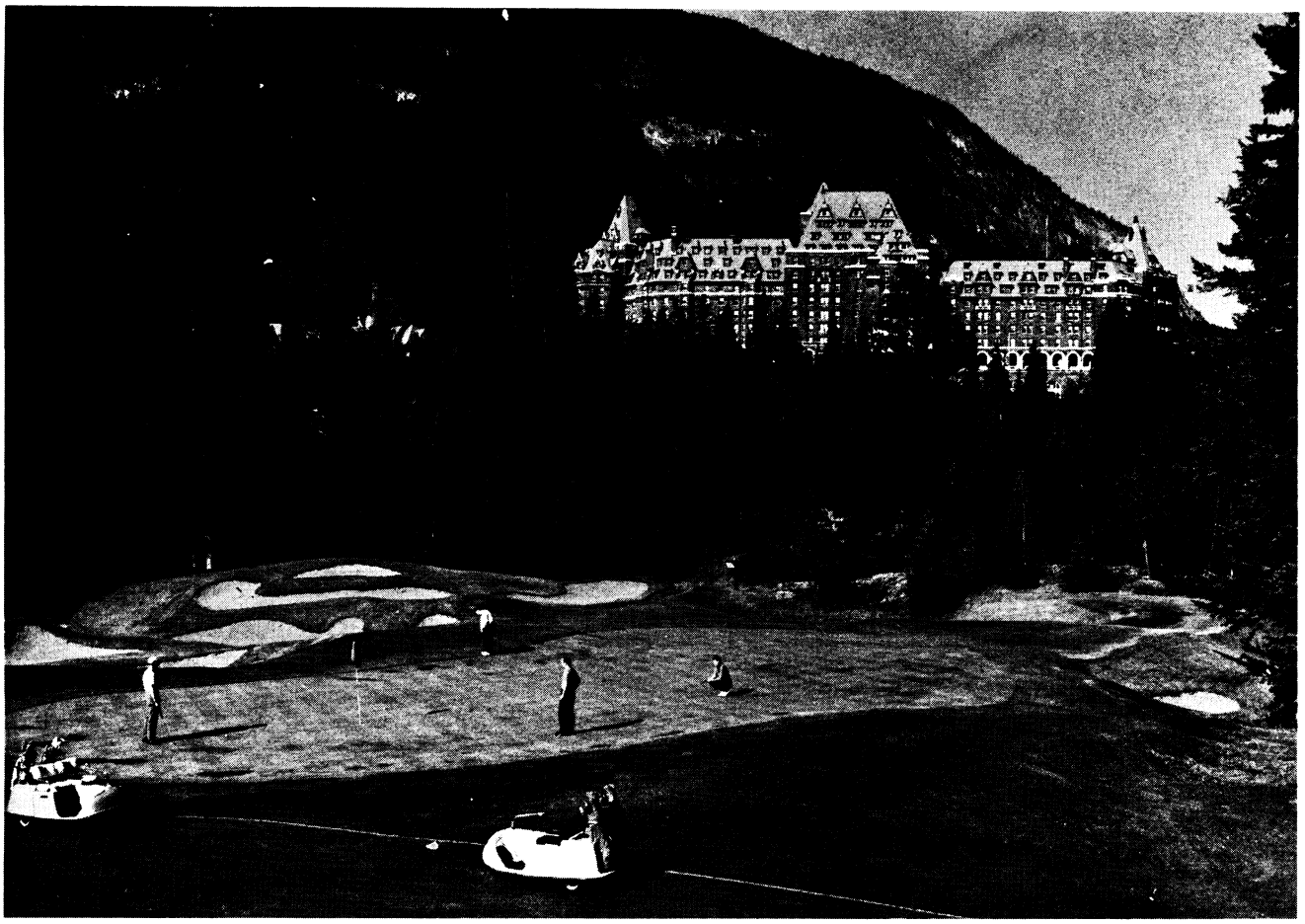
August
Adolescent Psychiatry

September
Obstetrics and Gynecology

October
General Medicine

November
Cardiopulmonary Disease

December
Surgery in Family Practice



Education and the Family Physician

The Theme For

The 15th Annual Scientific Assembly

The College of Family Physicians of Canada

At The

Banff Springs Hotel

Banff, Alberta

September 13 to 16, 1971

Collecting and Restoring Early Canadian Furniture

D. W. McLENNAN, MD

In this the fifth in a series on leisure activities of Canadian physicians, College member Dr. McLennan of Grimsby, Ont. writes about how he got started – and deeply involved – in collecting Canadian antiques.

ANTIQUE fever may start with something as simple as a Captain's Chair. At least that's how it happened in our family. The medical office contained an old painted high-backed armchair that was very comfortable but a little incongruous with modern furnishings. In a weak moment I took it home, then stripped it of many colorful layers of old paint. Finally it was sanded and refinished in its natural color. The story should have ended there – but it didn't.

Well-meaning people commented on what an attractive chair it was. Gradually we learned that it was called a Captain's Chair – that it was of Canadian origin, and that it was made at about the turn of the century. What then could be more natural than to acquire another piece to determine if the first success had been merely a fluke?

Soon the basement, the attic, and the garage were full of Canadian antiques awaiting repair and refinishing. Within two years, much of our contemporary furniture had been replaced, several rooms were completely refurnished using "new" old pieces. A new room was built to accommodate several large acquisitions that would not fit elsewhere. We still compulsively search each new antique shop or auction for even more pieces. You see, it becomes an addiction!

Functional And Beautiful

As with most addicts, antiquers readily rationalize their cravings. First of all, antique furniture is functional and beautiful. I do not mean to imply that all pieces built 100 years ago were functional and beautiful, but as a rule only those that were so have survived to this time. They are well-built and have been used and loved by several generations. With the passage of years, they have acquired a glow and character not seen in new furniture.

Second, the pieces have an intrinsic value. Nobody makes dry sinks, dough-boxes, or blanket chests anymore. Thus, the collector feels that he is personally preserving some of our Canadian heritage.

And third, this furniture appreciates in value as it ages. The chrome and arborite kitchen set bought a mere five years ago would realize little or nothing if sold now. Each mark and scratch devaluates the set. The pine harvest table and a set of arrow-back chairs that serve the same function increase in value every year – and the marks and wear only enhance their charm. Finally, there is an indefinable satisfaction in rescuing a forsaken, neglected cupboard or table and restoring it to its original beauty.

I like to compare furniture to the three ages of man. When young, it is beautiful but rather lacking in character and charm. In middle age, it tends to look just that. However, in the fullness of time, like an old sailor, it acquires a dignity and patina that overshadows the infirmities that age brings.

Antique furniture is easy to live with. As it has passed "middle age", one no longer worries about the scratches and dents that wear inflicts. The knocks and bruises caused by the children simply add more character, and can be welcomed, or at least forgotten, rather than being the cause of a spanking. No need to worry about cigarette burns or heel marks here! They are all absorbed without apparent harm and all the while the value increases. Who could ask for more?

Related Pursuits

One of the wonderful benefits of antiquing is that it draws the family together and leads to other related pursuits. A pine commode looks much prettier with some color to set it off,

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that the prospective purchase will, in fact, fit in the area for which it is intended. I once bought a corner cupboard that would not enter the house by any door or window that existed. It did fit into the new den that we happened to build shortly after we bought the cupboard – even though the den had to be erected around it. But that is another story altogether.

The collector must be governed by the type of house he lives in. The older, gracious homes with ten-foot ceilings will accommodate anything that one is likely to buy. However, the owner of a ranch, or split-level home will have to content himself with the more compact antiques. Such items as the smaller dry sinks, dough boxes, chests of drawers, cradles, chairs and kitchen tables – all lend themselves to the modern home. Although early furniture can be blended with modern, I think that a whole room done in the early style is more charming.

Repairing

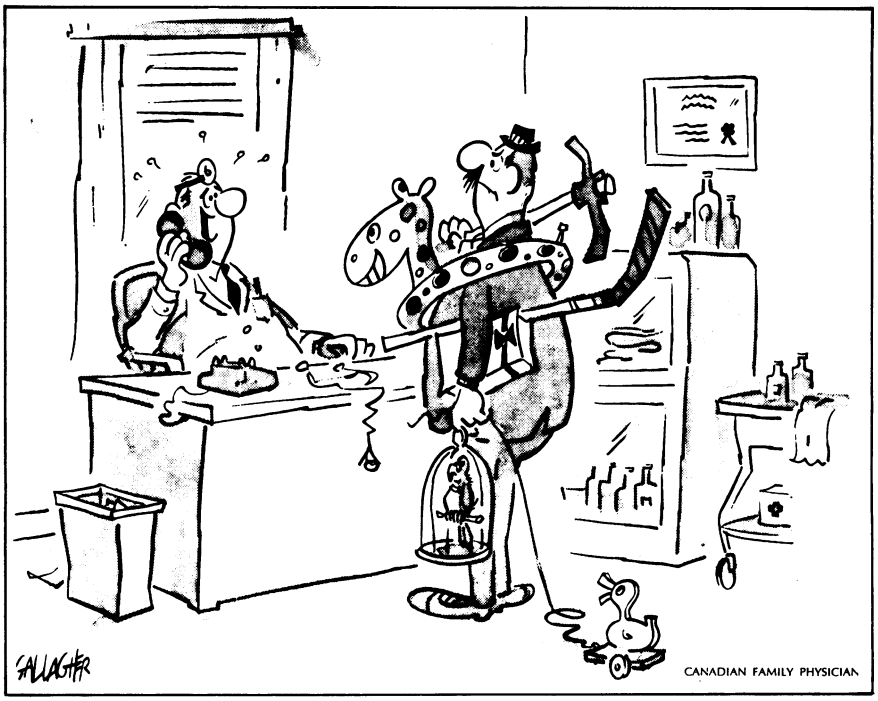
The subject of repairing early furniture is really too complex to deal with in this article. The problems are so individual that even reference texts all too often refuse to yield an answer. A fairly complete workshop is a great help. It is also important to collect old wood to use for the repairs. Some collectors buy worthless old junk just to get the aged wood for repairing more valuable pieces.

Replacing lost or broken hardware is the most difficult problem of all. Most antique dealers are reluctant to part with their hinges, knobs, or locks, because they need them for their own repairs. Fortunately, there are now places where excellent reproductions can be obtained. At the "Pillar and the Post" in Niagara-on-the-Lake, a blacksmith turns out an excellent selection of nails, wrought-iron hinges, thumb-latches, etc. He will also make up pieces to order. Antique Hardware, at 24 Birch Avenue, Toronto 7, also deals in these items. Square nails can often be obtained from old houses or barns that are being wrecked. Wide old pine boards can also be found here. A renovation at our office yielded several hundred square nails, and 100 feet of 20-inch wide pine boards. Considering that these nails fetch about a dime a piece, and the boards are virtually unobtainable, it was a valuable find!

Refinishing

Refinishing your acquisitions is a very satisfying pastime. I cannot stress too strongly the value of taking a picture before and after restoration. This practice also helps to establish the authenticity and age of the article. For simplicity, I will describe the method that I generally use to refinish an antique:

1. *Stripping.* First of all, the old finish is generally removed. The easiest and best way is to use a chemical solvent such as Polystrippa. This is best used in a well-ventilated area. It will soften two or three layers of paint



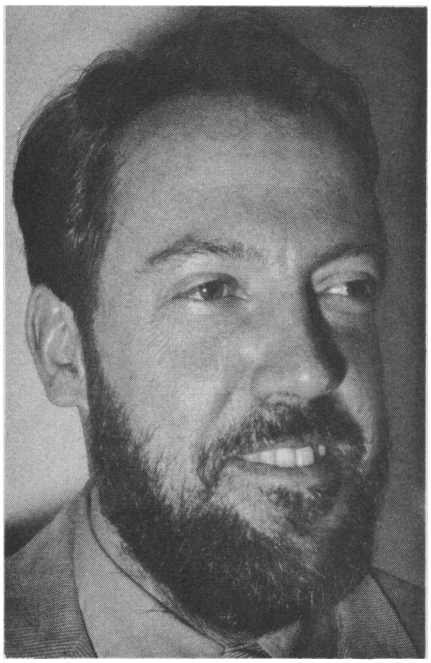
"Hello, Ajax pharmacy? I understand you had some difficulty reading my handwriting . . . "

or varnish at a time, and this can be removed with a putty knife. The process is repeated until bare wood is reached. I like to leave the old paint in the holes and cracks of the wood. This shows traces of the ancestry of the piece and also provides some color highlights. The wood is then sanded lightly to provide an even satin finish.

Some people recommend the use of paint scrapers or broken glass to remove the old finish. I mention this practice only to condemn it. This process removes the patina and leaves a rough, scarred finish that requires too much sanding.

2. *Repairs* After the repairs are completed, any variations in the shades of the wood used can be touched up with stains.

3. *Refinishing* Although many purists will disagree, I use urethane almost exclusively. This material is a plastic varnish commonly sold under the trade-name Varathane. Urethane is easy to apply, dries dust-free in one-half hour, and resists even alcohol and water stains. It does not crack or craze and, if struck, it merely dents with the wood. It is available in both satin and gloss finish. Three coats are a minimum, and I like to use five on a top surface or areas of heavy wear. A light sanding is required between each coat.



Dr. McLennan, a College member, is in group practice in Grimsby, Ont.

After the last coat, an excellent result can be obtained by rubbing in floor wax using the finest grade of steel wool.

The drawbacks to a urethane finish are that it is not "authentic", and it is most difficult to remove. Therefore, it is as well to be completely happy with your stripping and repairs before the urethane is applied.

There are many other finishes such as wax, varnish, etc. They are all hard work and require continuing care. I suspect that urethane has made them obsolete for the average hobbyist.

I hope that this article will stimulate in some of CANADIAN FAMILY PHYSICIAN'S readers an interest in antiques. In others, perhaps it will help explain the addiction of the collector. While I was flattered to be asked to write on this subject, it is acknowledged that others are much better qualified. Dr. Clark Noble of Richmond Hill is a collector and authority of renown. He has written the foreword to an excellent book on this subject titled *A Guide to Pre-Confederation Furniture of English Canada* by Don R. Stewart (Longmans).

Other useful books include *Antiques in Ontario* by Doris & Peter Unitt; *Unitts Price Guide to Canadian Antiques; The Furniture Doctor* by George Grotz (Doubleday); *The Complete Book of Furniture Repair and Refinishing* by Ralph Parsons Kenney (Scribners). Finally, a beautiful classic book in the coffee-table style is *The Early Furniture of French Canada* by Jean Palardy. ◀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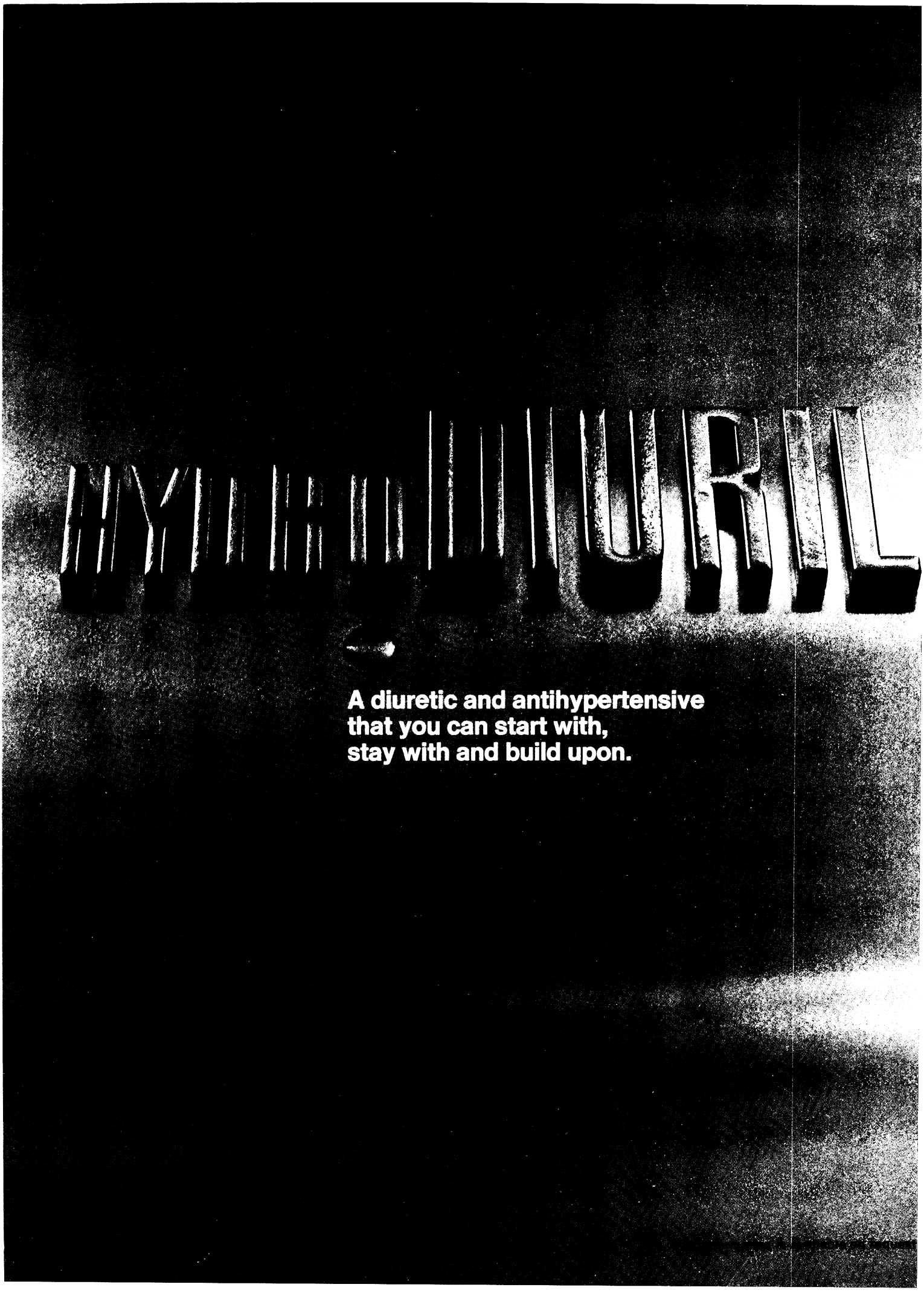
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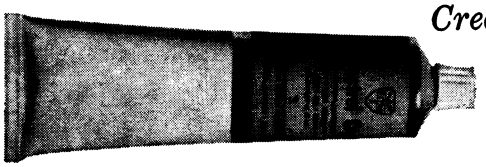

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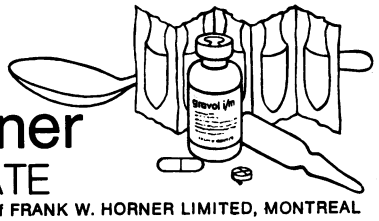

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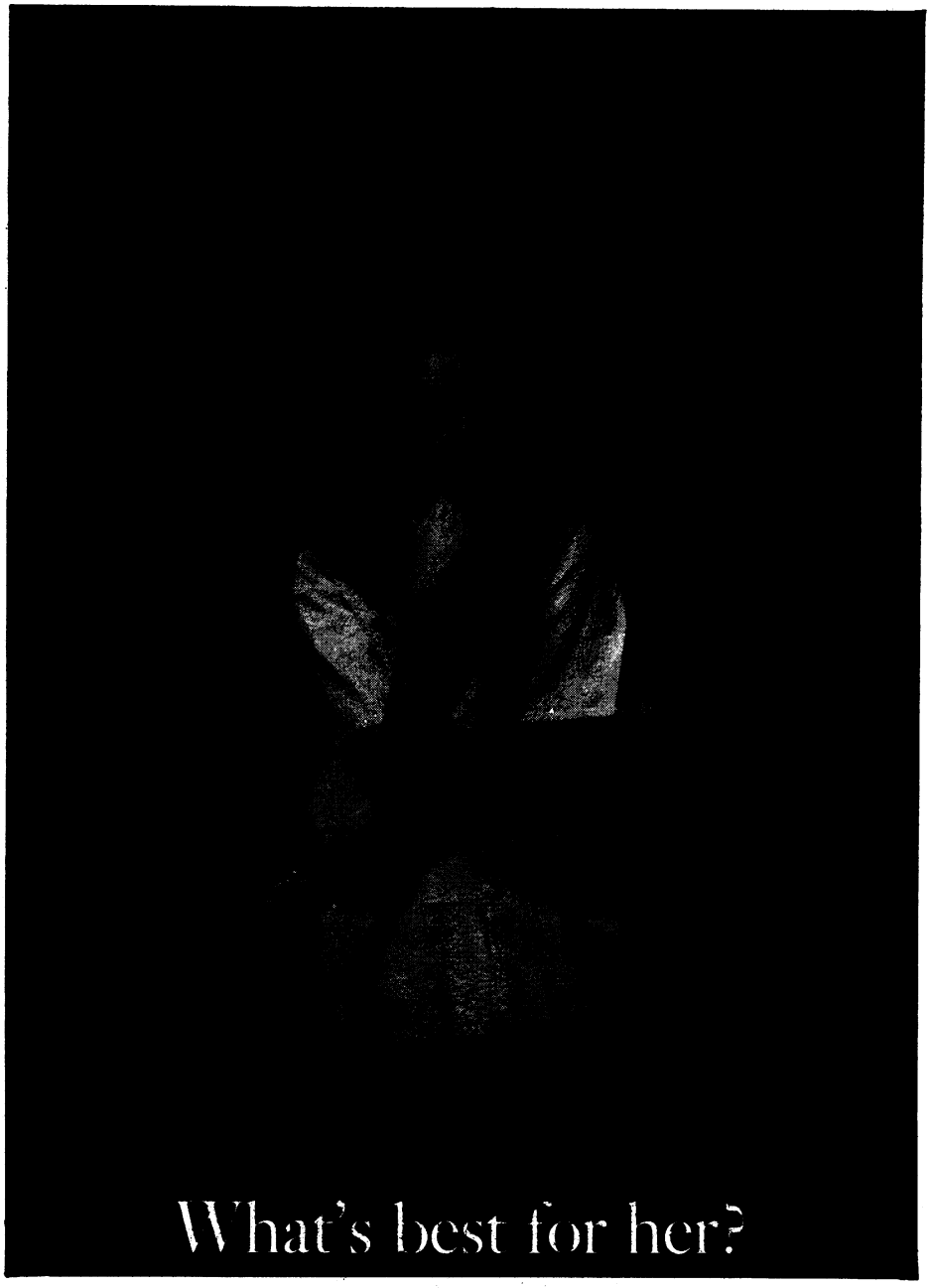

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48 pourcent environ de ces patients souffrent d'une forme ou l'autre de paralysie par encéphalopathie, 4 pourcent environ sont paralysés et 17 pourcent environ ont plusieurs genres de maladies du système nerveux central y compris des maladies dégénérescentes du système nerveux central. Cinq pourcent environ ont des maladies de la moëlle épinière et des nerfs périphériques, environ trois pourcent ont des maladies primaires des muscles et environ huit pourcent ont des problèmes affectant l'ouïe et la parole.

Le pronostic des enfants aux handicaps multiples dépend, bien entendu, de la sévérité de l'handicap et du degré d'indépendance auquel l'enfant pourra atteindre. Un jeune adulte-type qui a été frappé de paralysie par encéphalopathie est généralement une personne qui a un niveau d'éducation primaire, occupe un emploi facile, ne possède aucune indépendance financière, est célibataire, vit chez lui avec sa famille, s'occupe fort peu des affaires de la communauté et a peu d'amis. On a observé dans un large groupe de jeunes adultes frappés de paralysie par encéphalopathie que 22 pourcent environ s'étaient bien adaptés socialement et étaient employés à plein temps. Les quadriplégiques spastiques ou les personnes frappées de paralysie par encéphalopathie mixte avaient des occupations qui n'entrainaient aucune compétition.

Les chances offertes à ces personnes d'apprendre un métier sont insuffisantes. Il faudrait pouvoir leur offrir un choix de métier lorsqu'ils quittent Glenrose. Dans une société régie par le travail, ces jeunes gens seront relégués dans une institution s'ils sont incapables de gagner leur vie. Si on les aidait davantage dans ce sens, 60 pourcent d'entre eux environ pourraient jouer un rôle utile dans la société. Comme nous l'avons fait remarquer plus haut, le genre d'emploi que ces individus peuvent obtenir dépend avant tout de la sévérité de leur handicap et du degré d'indépendance qu'ils ont pu atteindre. Suivant une étude récente 83 pourcent d'hémiplégiques, 44 pourcent de diplégiques et 36 pourcent de personnes atteintes d'athétose pouvaient exercer un métier. La possibilité d'employer ces jeunes personnes varie de 50 à 85 pourcent. En général une personne handicapée fait preuve d'immaturité et de manque de réalisme. C'est probablement là le résultat du milieu protecteur où elle a vécu avant d'atteindre le marché du travail. Les personnes qui s'occupent de ces enfants devraient les encourager à établir un équilibre réaliste entre leurs aspirations, leurs talents et les buts qu'ils désirent atteindre. Il ne faut pas leur donner un point de vue d'ensemble tendant trop à l'optimisme. ◀

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